

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02292

Item #2a b c & d Film #G387 3/28/67 ps

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02288

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY PRINCE WILLIAM			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 6 1/2 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) QUANTICO / St. Petersburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL				d. STREET ADDRESS NONE / 2840 Valencia Way, S		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hunton Beauchamp ALLEN Jr.				4. DATE OF DEATH Month FEBRUARY Day 22 Year 19 67			
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 JULY 1944	9. AGE (In years last birthday) yrs. 22	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILITARY		10b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.		11. BIRTHPLACE (State or foreign country) ROME, GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hunton Beauchamp ALLEN Sr.				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 261 68 9466		17. INFORMANT Address MARINE CORP RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8234 SEVERE LACERATION AND CONFUSION OF BRAIN WITH SKULL FRACTURE DUE TO (b) TRAUMA FROM AUTO ACCIDENT DUE TO (c) 9 1/2 HOURS						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car. that went out of control on Highway.					
20c. TIME OF INJURY Month, Day, Year 2:10 AM 2-22 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY		20f. (City or town) (County) (State) DUMFRIES VA.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
EXAMINER'S NAME (Type) JOHN G. BALL		23. DATE SIGNED 23 FEB 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-27-67		23c. NAME OF CEMETERY OR CREMATORY CHURCHYARD WILLIAMSON METHODIST		23d. LOCATION (City or Town) (County) (State) WILLIAMSON PKE GEORGIA	
24. FUNERAL DIRECTOR ADDRESS W.W. CHAMBERS, 1400 CHAPIN ST, NW, WASH., D.C.				25a. REC'D BY REGISTRAR DATE 23 FEB 67		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02289

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>3 McKay Circle</u>	
3. NAME OF DECEASED (Type or print) <u>Carolyn Jean Anderson</u>		4. DATE OF DEATH <u>Feb. 14 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1964</u>
9. AGE (In years lost birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donald E. Anderson</u>		14. MOTHER'S MARRIED NAME <u>Therese Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Donald E. Anderson</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Obstruction of larynx (below vocal cords)</u> DUE TO (c) <u>Aspirated aspirin tablet (Accidental)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Internal hydrocephalus (with shunt by Torgelson tube) advanced.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Inhaled - Aspirin tab.</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:15 p.m. 2/14 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cabin John</u> (County) <u>Mont.</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Ball</u>		22. DATE SIGNED <u>2/14/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Feb 20 1967</u>	
5130 Wisc. Ave. N.W. Wash. DC.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02294

CERTIFICATE OF DEATH

02290

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b 1 hr	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 3533 Marlborough Way	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Morris Middle NMI Last Arkow		4. DATE OF DEATH Month 2 Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/95
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months 1 Days 14	11. IF UNDER 24 HRS. Hours 14 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Op		10b. KIND OF BUSINESS OR INDUSTRY Garment	11. BIRTHPLACE (County & State, or foreign country) Poland, Warsaw
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Victor	
14. MOTHER'S MAIDEN NAME Rose		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 340107764		17. INFORMANT son in law Address Same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: ARTERIOSCLEROTIC & DEGENERATIVE DUE TO 6 YRS		INTERVAL BETWEEN ONSET AND DEATH 1 HR IN R.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIOSCLEROSIS & PROSTATIC HYPERTROPHY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from NOV 4 , 1966 to FEB 14 , 1967, that (I) (we) last saw the deceased alive on 1/15 , 1967, and that death occurred at 9:00 M, from causes and on the date stated above.	
22a. SIGNATURE Harold Lippmann		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) HOROWITZ, S. (M.D.)		22d. ADDRESS 1352 UNIV. BLVD E. HYATTSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2/15/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE FEB 16 1967	

Cleared by Dr. Reap

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 23c, 23d Film G386 3/5/67 mh

02295

CERTIFICATE OF DEATH

02291

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>...</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1660 LAMIER PLACE N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mauda</u> Middle <u>Hunter Ballard</u> Last <u>...</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-85</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>...</u> Days <u>...</u> IF UNDER 24 HRS. Hours <u>...</u> Min. <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MAX Aaron Collins</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mrs. Dorothy Dunn</u>		Address <u>9402 Woodland Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> DUE TO <u>Thrombophlebitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>...</u> (c) <u>...</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/2</u> , 19 <u>67</u> , to <u>2/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>67</u> , and that death occurred at <u>5 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Dr. Wheaton, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 18, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u> DATE <u>FEB 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02296

CERTIFICATE OF DEATH

02292

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Atlantic Atlantic County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sophie no middle name Barron				4. DATE OF DEATH Month Day Year 2 3 1967			
5. SEX Female	6. COLOR OR RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1892	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia	
13. FATHER'S NAME Benjamin Aronoff				14. MOTHER'S MAIDEN NAME Frieda			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery sclerosis 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 11 JAN 1967 , to 3 FEB 1967 , that (I) (we) last saw the deceased alive on 2 FEB 1967 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Paul T. Noone				22b. DATE SIGNED 2/3/1967			
22c. PHYSICIAN'S NAME (Type) Paul T. Noone				22d. ADDRESS 5201 Randolph Rd., Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-5-67	23c. NAME OF CEMETERY OR CREMATORY Philadelphia Cemetery	23d. LOCATION (City, town or county) (State) Philadelphia, Pa.				
24. FUNERAL DIRECTOR Goldberg Funeral Home				25. REGISTRAR'S SIGNATURE Charles Judge			

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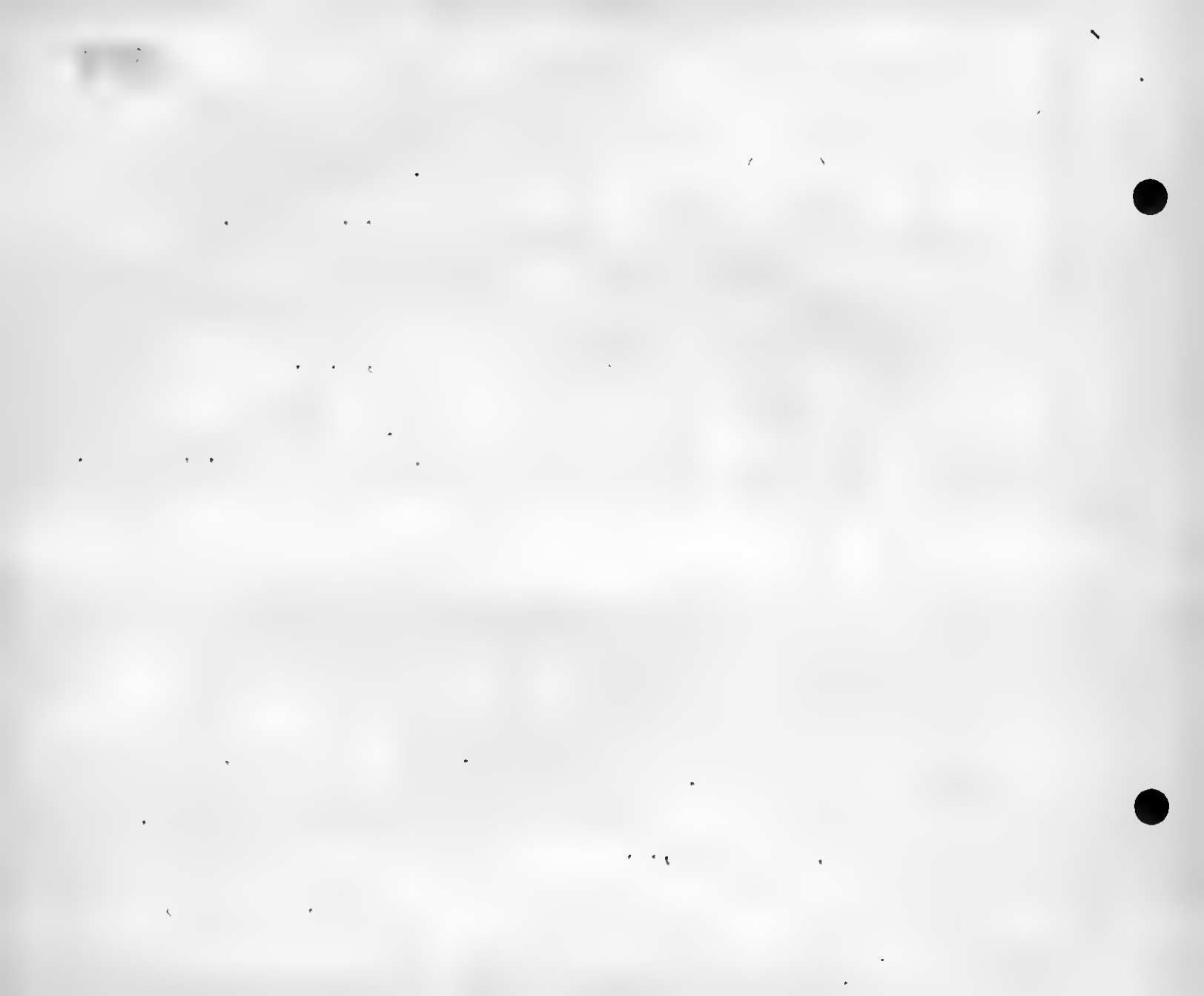
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE Florida b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN lb 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 1180 S.W. 26th Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last Elizabeth Anne BARTLETT		4. DATE OF DEATH Month Day Year February 26 19 67	
5 SEX Female	6. COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 23 October 1915
9 AGE (In years last birthday) 51 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY N/A	
11 BIRTHPLACE (County & State, or foreign country) New York, N. Y.		12 CIT ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael McMAHON		14. MOTHER'S MAIDEN NAME Elizabeth BOHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 131-14-6736	
17. INFORMANT Clinton D. BARTLETT		Address Ft. Lauderdale Florida	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional Cirrhosis with bleeding diathesis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20a INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Feb. 11 , 19 67 , to Feb. 26 , 1967, that (X) (we) last saw the deceased alive on Feb. 26 , 19 67 , and that death occurred at 1100AM , from causes and on the date stated above			
22a SIGNATURE R. J. Kinney		22b. DATE SIGNED Feb. 27, 1967	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY, M.D.		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3-2-67	23c. NAME OF CEMETERY OR CREMATORY Queen of Heaven	23d LOCAT ON (City or town) (County) (State) Ft. Lauderdale, Florida
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Maryland		25a REC'D BY REGISTRAR MAR 8 1967	25b REGISTRAR'S SIGNATURE Charles Judge



02297

CERTIFICATE OF DEATH

02293

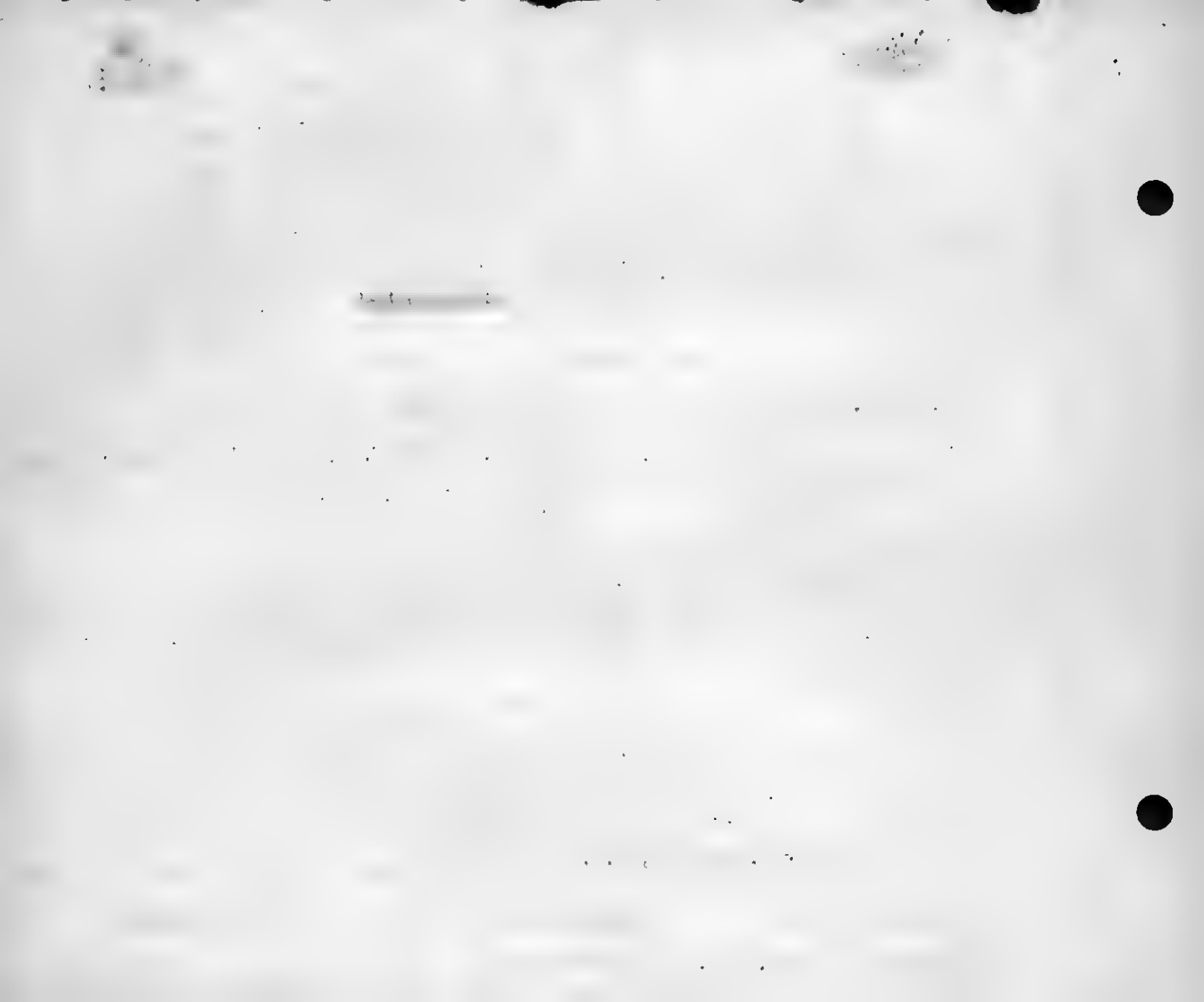
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d STREET ADDRESS Washington Grove	
3 NAME OF DECEASED (Type or print) John Herbert Becraft		4 DATE OF DEATH Month 2 Day 7 Year 19 67	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-28-96
9 AGE (In years last birthday) yrs 71		IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Becraft		14 MOTHER'S MAIDEN NAME Katie Penn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-03-9120	
17. INFORMANT Medical Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Toxic hepatitis, cause undetermined 1992 DUE TO (b) 2) Adrenal failure, sec. to (3) DUE TO (c) 3) Anaplastic carcinoma, metastatic, adrenals (massive), kidneys, heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diagnosis: liver metastatic carcinoma, adrenal failure, anaplastic carcinoma			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-17-67 to 2-7-67 , that (I) (we) last saw the deceased alive on 2-6-67 19 67 , and that death occurred on 2-7-67 at 11:45 a.m., from causes and on the date stated above.			
22a. SIGNATURE Frederick Moomau M.D.		22b DATE SIGNED 2-8-67	
22c. PHYSICIAN'S NAME (Type) Frederick Moomau, M. D.		22d ADDRESS Medical Center, Sandy Spring, Md.	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial	23b DATE THEREOF 2-10-67	23c NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City or town) (County) (State) Gaithersburg Montg. Md
24. FUNERAL DIRECTOR Ernest C. Gartner		25a. REC'D BY REGISTRAR DATE FEB 10 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
02298 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HCY CROSS HOSPITAL</u>					02294 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>10807 GEORGIA AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>IRVING A BEHEMAN</u> First Middle Last			4. DATE OF DEATH <u>2 21 1967</u> Month Day Year		5. SEX <u>MALE</u>			6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Delicatessen</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>?</u>			
13. FATHER'S NAME <u>William W. Behrman</u>					14. MOTHER'S MAIDEN NAME <u>Mary ?</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>579-01-2567</u>		17. INFORMANT <u>Mrs. Fannie R. Behrman</u> Address <u>10807 Georgia Avenue</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding peptic ulcer</u> 5400 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, arteriosclerosis obliterans, coronary heart disease</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> , 1954, to <u>Feb 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>Feb 20</u> , 1967, and that death occurred at <u>1:50 P.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Arthur S. Bresler</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>Feb 21, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Bresler, M.D.</u>					22d. ADDRESS <u>10881 Lockwood Drive, Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Adath Jeshurun</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>					25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02299

CERTIFICATE OF DEATH

02295

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN TB 8 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 3207 Emory Church Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gladys		First Cecelia		Middle Belding		Last		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-26-96		
9. AGE (In years lost birthday) 70 yrs		IF UNDER 1 YEAR Months 1 Days 19 Hours 67		IF UNDER 24 HRS Months 1 Days 19 Hours 67				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME David Poore				
14. MOTHER'S MAIDEN NAME Gladys Murphy				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None				
16. SOCIAL SECURITY NO. 577-07-0311-8				17. INFORMANT Chester L. Belding Medical Center				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Pulmonary Embolism RT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pulmonary artery (c) Perforated Gastric Ulcer				INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days				
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction (old)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/29 , 19 67 to 2/1 , 19 67 that (I) (we) last saw the deceased alive on 2/1 , 19 67 , and that death occurred at 11:35 AM from causes and on the date stated above.								
22a. SIGNATURE [Signature]				22b. DATE SIGNED 2/1/67				
22c. PHYSICIAN'S NAME (Type) A. D. Connerant, M.D.				22d. ADDRESS Medical Center, Sandy Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Glen Carter Warner & Humphrey, Inc.				25a. REC'D BY REGISTRAR ECB b 1967				
25b. REGISTRAR'S SIGNATURE [Signature]								



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02300

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

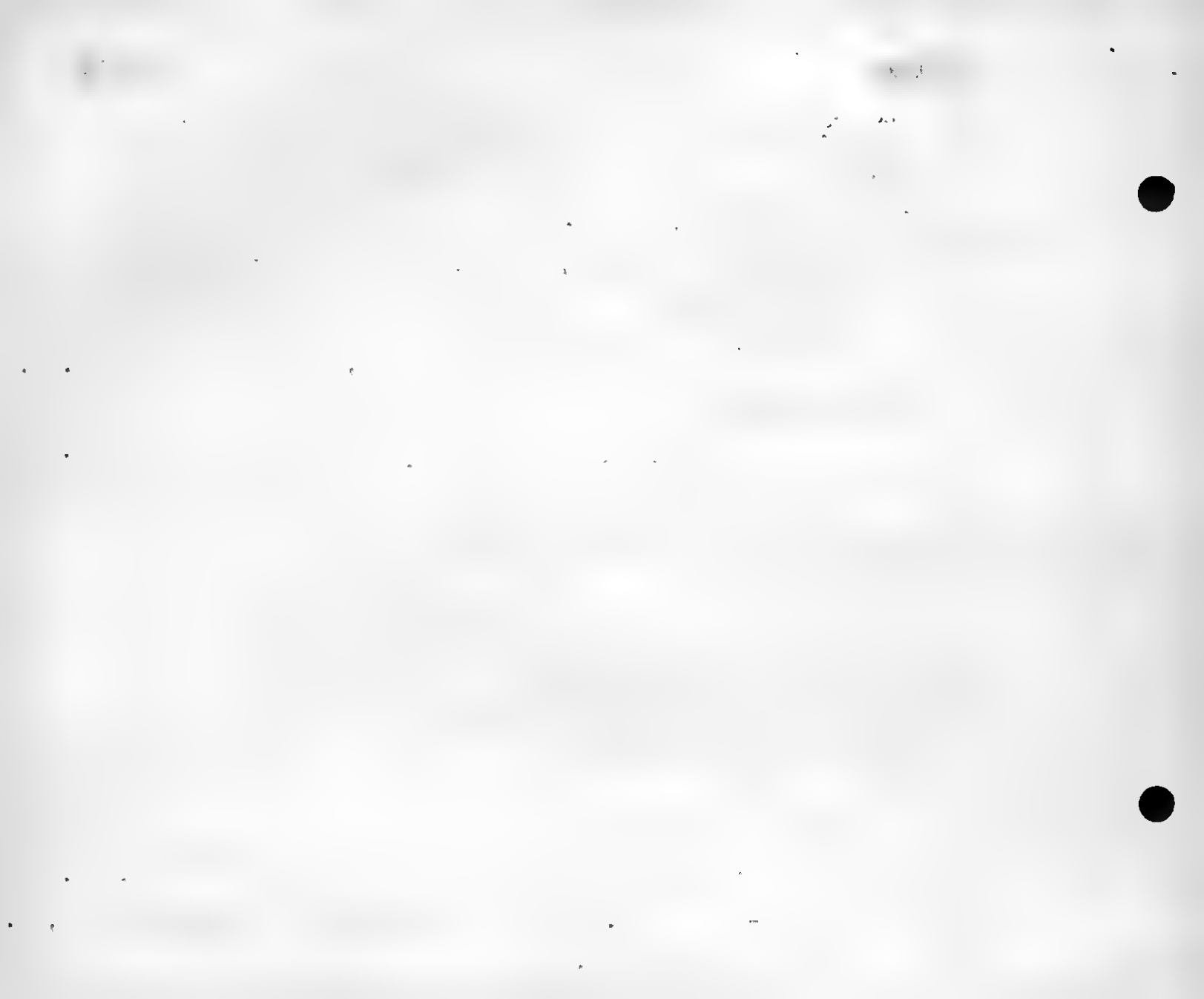
02296

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>263 Congressional Lane Apt. 219</u>		d. STREET ADDRESS <u>263 Congressional Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Julia Bell Berry</u>		4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. CO. OR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1917</u> 49 yrs
9. AGE (In years lost birthday) <u>49</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lexington, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Edward Quesinberry</u>		14. MOTHER'S MAIDEN NAME <u>Katie Belle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>228-09-8344</u>	
17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate Poisoning</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>	
DUE TO <u>overdose of Trional</u>			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Took overdose of Trional</u>	
20c. TIME OF INJURY Month, Day, Year Hour am <u>4:30</u> <u>pm</u> <u>2/23</u> <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Rockville</u> <u>Montg.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>2/24/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>William J. Young</u>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02301

CERTIFICATE OF DEATH

02297

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 406 Hinsdale Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 406 Hinsdale Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RACHEL First Middle Last BERRY		4. DATE OF DEATH Month Day Year 2 4 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/70
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days 96	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME MAX MARGOLIES		14. MOTHER'S MAIDEN NAME SARAH REBECCA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Asriel Berry 406 Hinsdale Ln. S.S.Md.	
17. INFORMANT Asriel Berry 406 Hinsdale Ln. S.S.Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 421 C DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Emboli.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967 to Feb 4, 1967 , that (I) (we) last saw the deceased alive on 2/3 19 67 , and that death occurred at 2 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Samuel Dessoff		22b. DATE SIGNED 2/4/67	
22c. PHYSICIAN'S NAME (Type) Samuel Dessoff, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION (City, town or county) (State) Hyattsville, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons			
ADDRESS 3501-14th St., NW, Wash. D.C.			
25a. REC'D BY REGISTRAR FEB 7 1967			
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

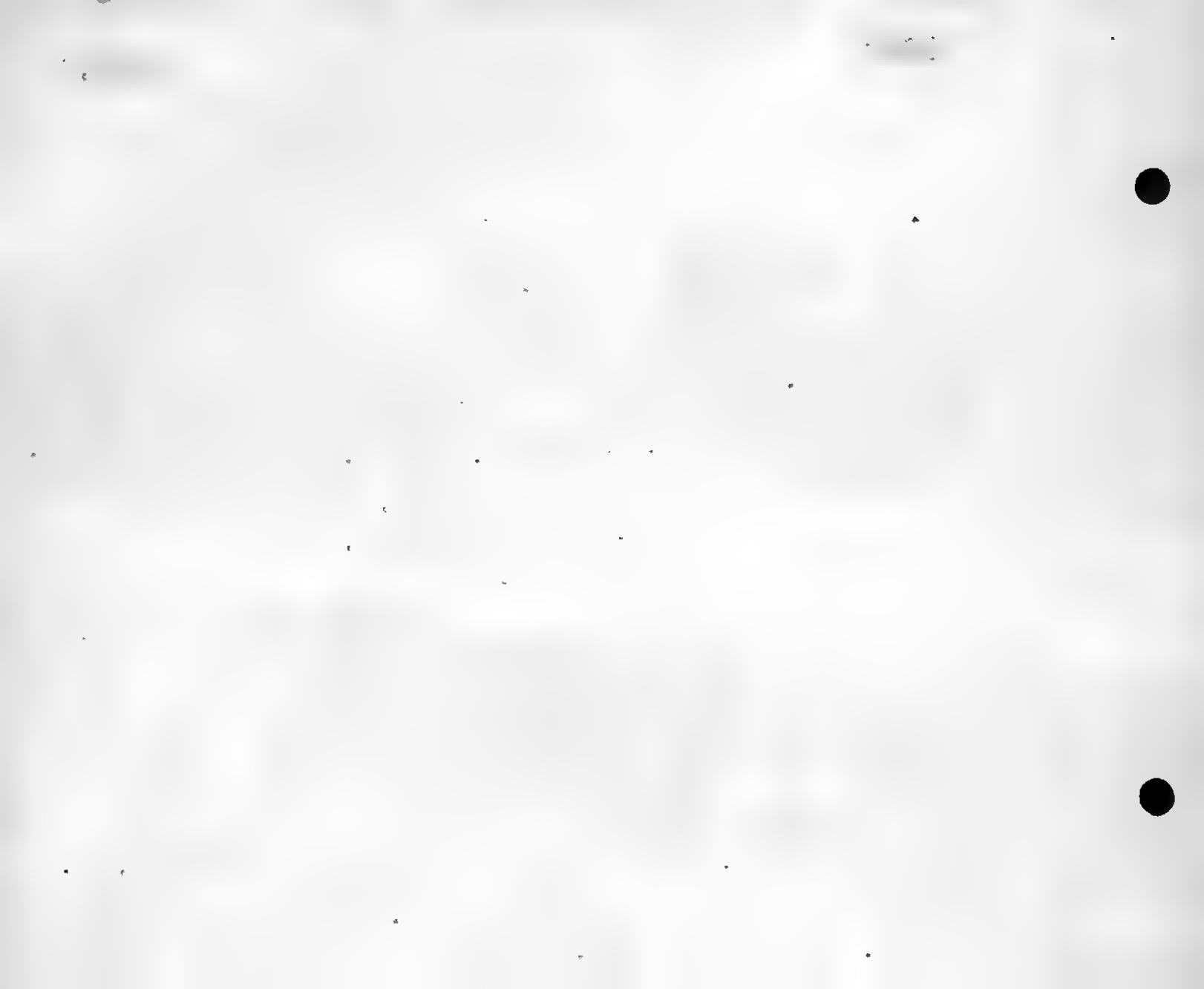
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02302

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02298

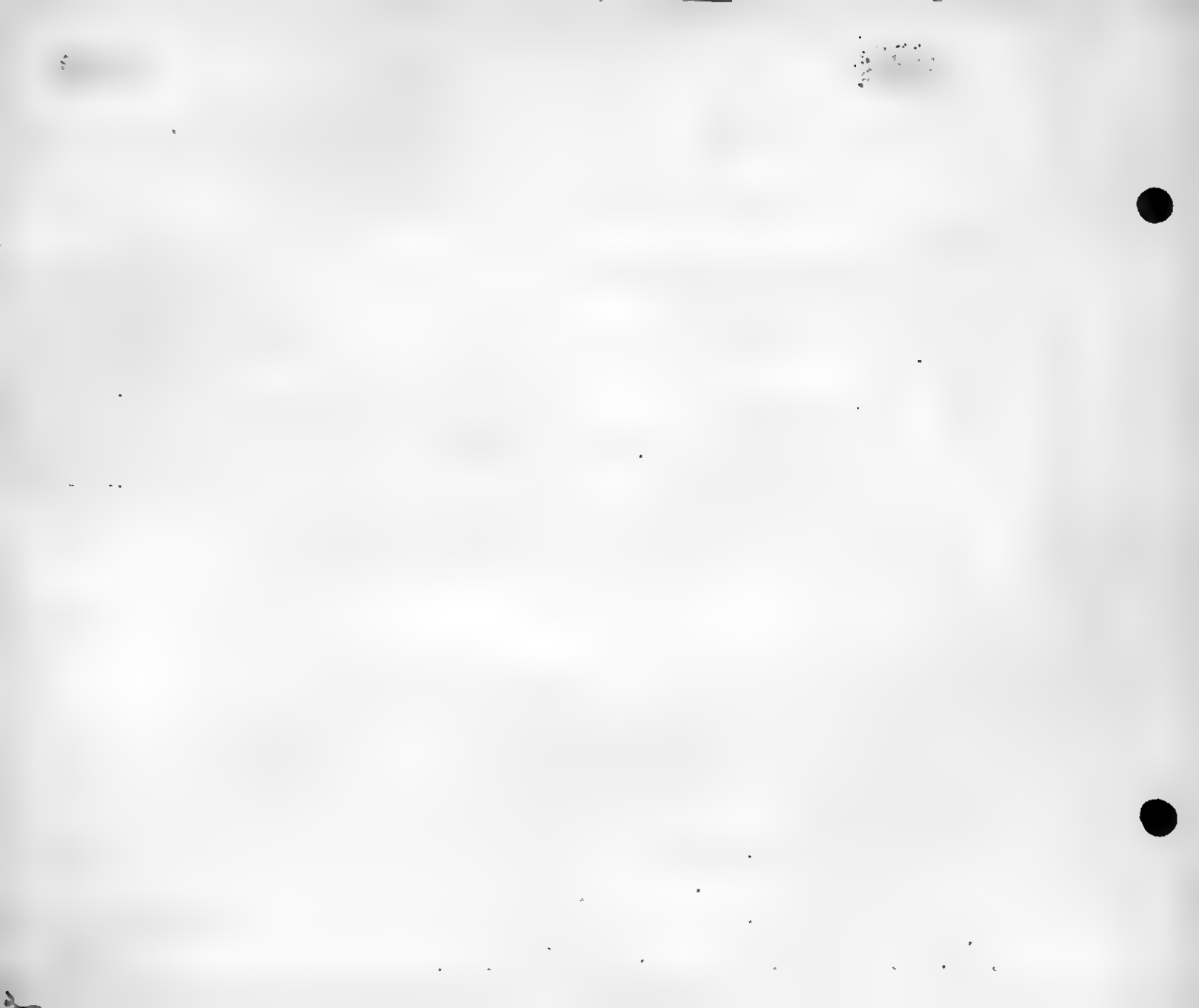
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
c. LENGTH OF STAY IN 1b. <u>60.0.0.</u>		15- <u>15-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>10558 MacArthur Blvd.</u>	
3 NAME OF DECEASED (Type or print) <u>John Winfield Bissett</u>		4 DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-21-88</u>
9 AGE (In years and months) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas E. Bissett.</u>		14 MOTHER'S MAIDEN NAME <u>Nancy Kitchen.</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I.</u>		16 SOCIAL SECURITY NO. <u>577-40-4042</u>	
17 INFORMANT <u>Sister</u> Address <u>Same as Item 2.</u>		Mrs. Elgia N. Cooley	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Cardiac Tamponade, sudden</u> DUE TO (b) <u>Ruptured dissecting aneurysm, arch of aorta</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>sudden</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>2/17/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24 FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>13</div> <div>14</div> <div>15</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div> <div>26</div> <div>27</div> <div>28</div> <div>29</div> <div>30</div> <div>31</div> <div>32</div> <div>33</div> <div>34</div> <div>35</div> <div>36</div> <div>37</div> <div>38</div> <div>39</div> <div>40</div> <div>41</div> <div>42</div> <div>43</div> <div>44</div> <div>45</div> <div>46</div> <div>47</div> <div>48</div> <div>49</div> <div>50</div> <div>51</div> <div>52</div> <div>53</div> <div>54</div> <div>55</div> <div>56</div> <div>57</div> <div>58</div> <div>59</div> <div>60</div> <div>61</div> <div>62</div> <div>63</div> <div>64</div> <div>65</div> <div>66</div> <div>67</div> <div>68</div> <div>69</div> <div>70</div> <div>71</div> <div>72</div> <div>73</div> <div>74</div> <div>75</div> <div>76</div> <div>77</div> <div>78</div> <div>79</div> <div>80</div> <div>81</div> <div>82</div> <div>83</div> <div>84</div> <div>85</div> <div>86</div> <div>87</div> <div>88</div> <div>89</div> <div>90</div> <div>91</div> <div>92</div> <div>93</div> <div>94</div> <div>95</div> <div>96</div> <div>97</div> <div>98</div> <div>99</div> <div>100</div> </div>															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH						02299									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>✓</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Oak Haven Convalescent Home</i>						d. STREET ADDRESS <i>1325 Fern St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>Jones</i> Last <i>Blick</i>						4. DATE OF DEATH Month <i>Feb</i> Day <i>7</i> Year <i>1967</i>									
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 8, 1880</i>		9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>16</i>		IF UNDER 24 HRS. Hours <i>16</i> Min. <i>00</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington DC.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>William T. Jones</i>						14. MOTHER'S MAIDEN NAME <i>Annie Elizabeth Keliker</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>						16. SOCIAL SECURITY NO. <i>220-54-0826-2</i>						17. INFORMANT <i>Margaret Jones</i> Address <i>1325 Fern St. Washington DC.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Voluntary asphyxia</i> 331X DUE TO (b) <i>Cerebrovascular accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>3 days</i>												INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>venous thrombosis and pulmonary embolism</i>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>10/1/66</i> , 19 <i>19</i> to <i>2/7/67</i> , 19 <i>19</i> , that (I) (we) last saw the deceased alive on <i>2/6/67</i> , 19 <i>19</i> , and that death occurred at <i>4:50</i> p.m. from the causes and on the date stated above.															
22a. SIGNATURE <i>Patrick Jameson</i>												22b. DATE SIGNED <i>2/7/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Patrick Jameson</i>						22d. ADDRESS <i>11718 George Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Feb 10, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Washington D. C.</i>					
24. FUNERAL DIRECTOR <i>E. Glen Carter</i> <i>Warner E. Pumphrey, Inc</i>						25a. REC'D BY REGISTRAR <i>Charles J...</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>									
DATE <i>FEB 14 1967</i>															



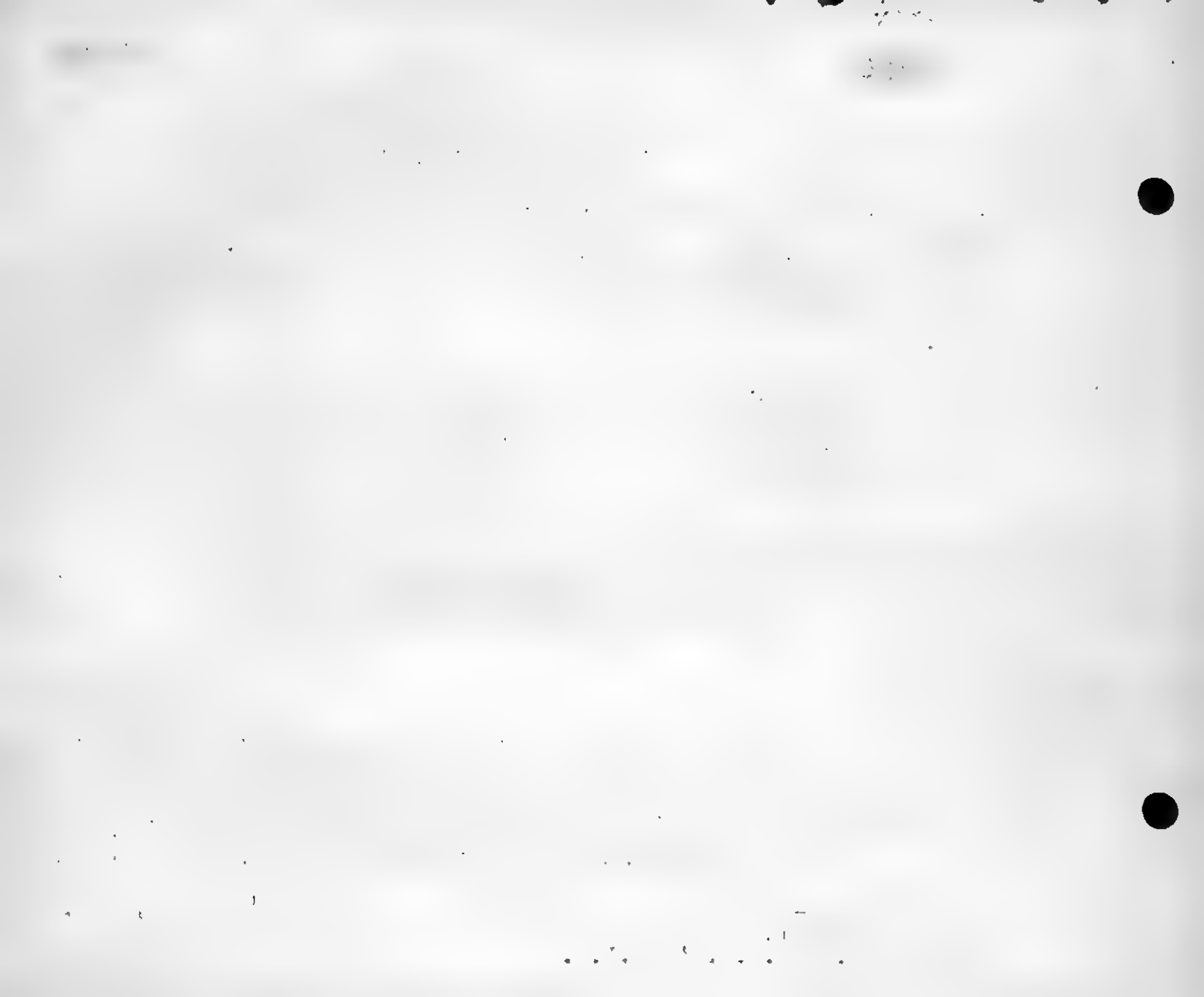
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02300											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Downer's Grove</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>39 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Downer's Grove</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>						d. STREET ADDRESS <u>1240 Gilbert Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>Bluder</u>						4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 May 1946</u>		9. AGE (in years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Roland Bluder</u>						14. MOTHER'S MAIDEN NAME <u>Alice Frazier</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Md. 20014</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>440A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Septicemia</u> OUE TO (c) <u>Bilateral pneumonia with pleural and pericardial involvement</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic myelogenous leukemia with blast crisis</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>4 minutes</u> <u>24 hours</u> <u>2 weeks</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <u>ON</u> (this hospital) attended the deceased from <u>11 January, 1967</u> to <u>19 Feb. 1967</u> , that <u>XX</u> (we) last saw the deceased alive on <u>19 Feb. 1967</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Myron J. Levin</u>											
22b. DATE SIGNED <u>Feb. 19, 1967</u>											
22c. PHYSICIAN'S NAME (Type) <u>Myron J. Levin, M.D.</u>											
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>2-20-1967</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <u>Downer's Grove, Ill.</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>						25a. REC'D BY REGISTRAR <u>Feb 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7, 11, 12, 13, 14 Film 3286 2/15/67 mh
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02305

02301

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7503 Palmer Lane		d. STREET ADDRESS 7503 Palmer Lane	
3. NAME OF DECEASED (Type or print) First GLENN Middle EUGENE Last BOONE		4. DATE OF DEATH Month February Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-17
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gasoline	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther C. Boone		14. MOTHER'S MAIDEN NAME Lesslie Holdaway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.		22. DATE SIGNED 2/15/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2/16/67	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State) Richmond Va
24. FUNERAL DIRECTOR William J. Dickner + Sons N. Va		25a. REC'D BY REGISTRAR FEB 20 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

02306

CERTIFICATE OF DEATH

02302

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>19 hr. 39 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>10301 Jewel Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Riley</u> First Middle Last				4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 23, 1967</u>		9. AGE (In years last birthday) yrs <u>19</u>	IF UNDER 1 YEAR Months <u>39</u>	IF UNDER 24 HRS Days <u>19</u> Hours <u>39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David F. Boston</u>				14. MOTHER'S MAIDEN NAME <u>Murtie Jo Head</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO —		17. INFORMANT <u>David F. Boston</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>116X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>19 hrs and 39 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 23, 1967</u> , to <u>February 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> 1967, and that death occurred at <u>4:55</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>H. H. Diamond</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u>				22d. ADDRESS <u>911 Silver Spring Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unionville Christian</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Montgomery, Md.</u>	
24. FUNERAL DIRECTOR <u>W. E. Engh</u>		ADDRESS <u>1500 W. Braddock Rd.</u>		25a. REC'D BY REG. STRA <u>ALEXANDER</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #14 infor. taken from birth cert.											
Items 4, 8 & 21 from Civil 8/30/68 bk											
02307						02303					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN lb <u>1 day +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>						d. STREET ADDRESS <u>8819 Ridge Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>B.</u> Last <u>Bradford</u>						4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>2-15-67</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>1</u> Days <u>21</u> Hours <u>45</u> Mins <u>56</u>		IF UNDER 24 HRS. Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. BRADFORD</u>						14. MOTHER'S MAIDEN NAME <u>Rebecca Ann Mills</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Father.</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth (3 lbs. 11½ oz.) neonatal death</u> DUE TO (b) <u>Pulmonary atelectasis</u> DUE TO (c) <u>762.5</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-11-67</u> , 19 <u>67</u> , to <u>2-17-67</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-6</u> , 19 <u>67</u> , and that death occurred at <u>8:15 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>John E. Cassidy M.D.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/6/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John E. Cassidy</u>						22d. ADDRESS <u>9911 O. O. GEORGETOWN RD BETHESDA</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>				23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Montgomery Md.</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>						25a. REC'D BY REGISTRAR <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02309

CERTIFICATE OF DEATH

02305

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8300 Woodhaven Blvd.		d. STREET ADDRESS 8300 Woodhaven Blvd.	
3 NAME OF DECEASED (Type or print) JOHN Spedden First Middle Last BRANNOCK		4. DATE OF DEATH Month 2 - Day 23 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1943
9 AGE (In years last birthday) 23 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Camp Counselor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harold Spedden Brannock		14. MOTHER'S MAIDEN NAME Janice Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Harold S. Brannock		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC GLOMERULONEPHRITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/9/62 , 19 62 , to 2/23/67 , 19 67 , that (I) (we) last saw the deceased alive on 2/23/67 , 19 67 , and that death occurred 1950 M, from causes and on the date stated above			
22a. SIGNATURE Henry C. Scruggs MD M.D.		22b. DATE SIGNED 2/23/67	
22c. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS MD		22d. ADDRESS 5413 Cedarlea Rd Bethesda MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-25-67	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 27 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
02308		CERTIFICATE OF DEATH						02304				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>709 Takoma St. Springville, Va.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>						d. STREET ADDRESS <u>9200 Bradford Road</u>						
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>MARIE</u> Last <u>BRAUN</u>						4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1876</u> <u>Feb 10 1876</u>		9. AGE (In years last birthday) <u>88</u> yrs.		10. FUNERAL 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Braun</u>						14. MOTHER'S MAIDEN NAME <u>Barbara Schramm</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Katherine B. Hiltz (same as #2)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility - Obstructive</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1967</u> to <u>Feb 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 16, 1967</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.												
22a. SIGNATURE <u>Philip E. Jones</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>2/26/67</u>						
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>						22d. ADDRESS <u>800 Pershing Dr NE Washington DC</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>March 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		23d. LOCATION (City, town or county) (State) <u>Washington DC</u>				
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		OATE <u>FEB 28 1967</u>				

02310

CERTIFICATE OF DEATH

02306

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home, Arcola Rd.</u>		d. STREET ADDRESS <u>3822 25th Place, N.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara Richardson Brown</u>		4. DATE OF DEATH Month Day Year <u>February 20 1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1888</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Suffolk, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>C.W. BOND</u>	
14. MOTHER'S MAIDEN NAME <u>MARY A. MARTIN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>W. BURCHER BROWN</u> Address <u>3211 VARNUM ST MD RAINIER, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>62</u> , to <u>2-20-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-19-</u> 19 <u>67</u> , and that death occurred at <u>3:42 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Lewis H. Biben</u>		22b. DATE SIGNED <u>2-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBEN</u>		22d. ADDRESS <u>916 19TH ST NW WASHINGTON DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>23 FEB 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>
24. FUNERAL DIRECTOR <u>Charles G. ...</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles G. ...</u>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

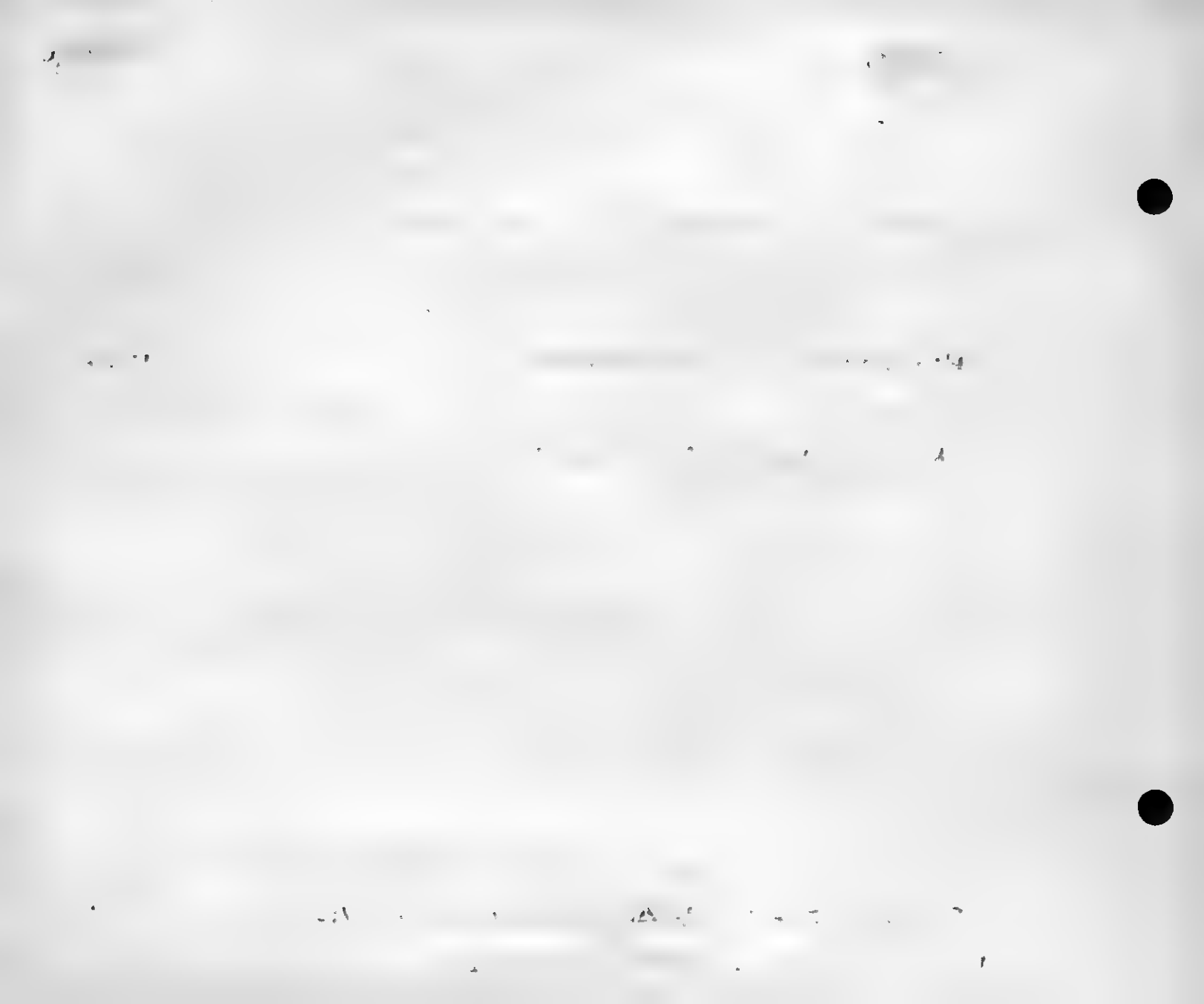
02311

CERTIFICATE OF DEATH

02307

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH STATE HOSPITAL</u>		d. STREET ADDRESS <u>10009 KENSINGTON PK</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET NMN BROWN</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-85</u> 82 yrs
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKER</u>	
10. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ANDREW DINKEL</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DINKEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>219-549325T</u>	
17. INFORMANT <u>CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Stroke with metastasis</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>6+ weeks</u> <u>years</u> <u>years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1st, 1967</u> to <u>Feb 11th, 1967</u> that (I) (we) last saw the deceased alive on <u>Feb 11th, 1967</u> and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Lyle W. Williams</u> M.D.		22b. DATE SIGNED <u>Feb 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lyle W. Williams</u>		22d. ADDRESS <u>831 University Blvd E Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>FEB 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>
24. FUNERAL DIRECTOR <u>LEC FUNERAL HOME, 300 4th St. N.E. WASH., D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02312

CERTIFICATE OF DEATH

02308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN Tb <u>5 mths</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cedar Haven Nursing Home</u>		d. STREET ADDRESS <u>7112 Holly Row</u>	
3 NAME OF DECEASED (Type or print) <u>HELEN (NMN) CALVIN</u>		4 DATE OF DEATH <u>FEBRUARY 7, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State of foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Schardt</u>		14. MOTHER'S MAIDEN NAME <u>Paula McKinstay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Jane Wilt</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Left Breast</u> DUE TO <u>Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Metastasis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 2, 1967</u> to <u>Feb 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 5, 1967</u> , and that death occurred at <u>3:44 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard T. Morse</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2/7/1967</u>
22c. PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>		22d. ADDRESS <u>Carroll Ave. Takoma Park, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hallidaysburg, Penna</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u> <u>254 Carroll St. N.W. Washington, D.C.</u>		25. RECEIVED BY REGISTRAR <u>FEB 9 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

4 . 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03757

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
c. LENGTH OF STAY IN lb. <u>19 days</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>	
d. STREET ADDRESS <u>R.F.D. #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEONA</u> Middle <u>B.</u> Last <u>CASE</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-92</u>
9. AGE (In years lost birthday) <u>74</u> yrs		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Louisville, Maryland</u>	
12. CIT. ZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Burdette</u>	
14. MOTHER'S MAIDEN NAME <u>Ida (Unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-12-7141</u>		17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>3. Bronchopneumonia</u> DUE TO (b) <u>Congestive heart failure - art. heart disease 10 yrs</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>2-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>2-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Ch. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

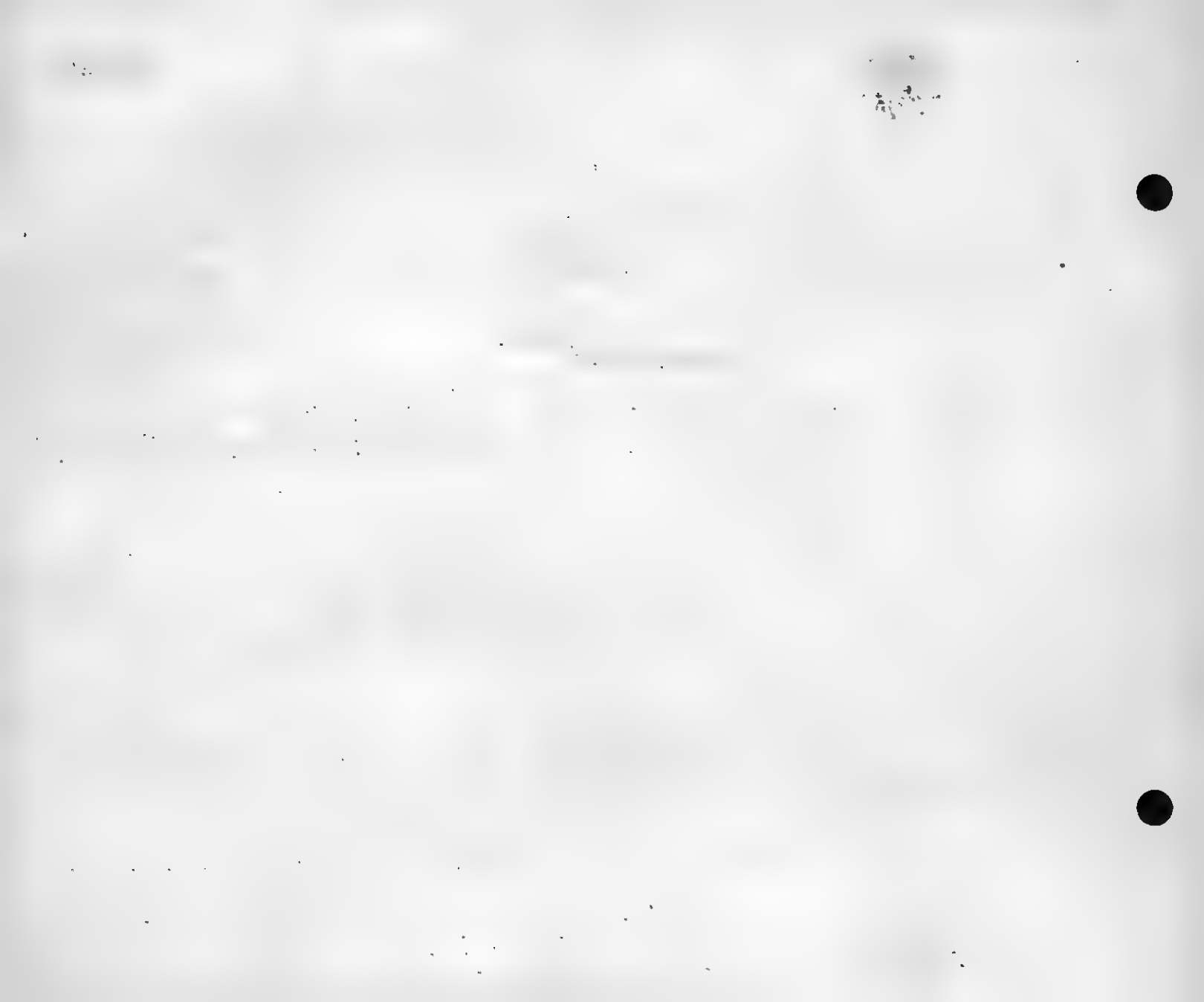
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02313

02309

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7712 Garland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Marion</u> First <u>Leslie</u> Middle <u>Chapin</u> Last		4. DATE OF DEATH <u>2</u> Month <u>14</u> Day <u>1967</u> Year		5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-19-08</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fitter - Garfinkel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Garfinkel</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Evans Leslie</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis DeChapin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>578-10-2825</u>				17. INFORMANT <u>Donald Chapin</u> Address <u>7712 Garland Ave. Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> DUE TO <u>1 hour</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary embolism</u> DUE TO <u>Minutes</u> (c) <u>Thromboses veins</u> DUE TO <u>Days</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>66</u> , to <u>Feb. 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-14-1967</u> , and that death occurred at <u>11:20</u> AM, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Kenneth Cruze</u> M.D.												22b. DATE SIGNED <u>2-14-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>Kenneth Cruze</u>												22d. ADDRESS <u>831 University Blvd. E., S. S., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb 17, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>							
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.</u>												25a. REC'D BY REGISTRAR <u>FEB 17 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02314

CERTIFICATE OF DEATH

02310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park, Md</u> c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs, Maryland</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. Hospital</u>				d STREET ADDRESS <u>100 Woodridge Ave</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Joseph (None) Chiang</u>				4 DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Chinese</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-10</u>	
9. AGE (In years last birthday) <u>57</u> yrs		10a. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired) <u>White House Correspondent (Associated Press)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (County & State, or foreign country) <u>China</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Americal-USA</u>				13. FATHER'S NAME <u>Unknown Chiang</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>NO</u> (If yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Mrs. Alice Chiang</u> Address <u>100 Woodridge Ave. Silver Spring Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1967</u> to <u>Feb 10, 1967</u> that (I) (we) last saw the deceased alive on <u>Feb 10, 1967</u> and that death occurred at <u>1:35 P.M. from causes and on the date stated above</u>							
22a. SIGNATURE <u>A. J. Thibadeau</u>				22b. DATE SIGNED <u>2-20-67</u>		22c. PHYSICIAN'S NAME (Type) <u>A. J. Thibadeau</u>	
22d. ADDRESS <u>1011 Colesville Rd., S. S., Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

02315

CERTIFICATE OF DEATH

02311

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN TB 5 hr. 15 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. STREET ADDRESS 11 N. Summit Drive.	
3 NAME OF DECEASED (Type or print) EDNA First Middle Last C. DEMONET CLARK		4 DATE OF DEATH Month February Day 21 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/90
9. AGE (in years last birthday) 76 yrs		IF UNDER 1 YEAR Months 21 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jules Demonet		14. MOTHER'S MAIDEN NAME Matilda Geist	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 063-10-4521B	
17. INFORMANT Hospital Records, Olney, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricle Strain (A.C.-H.F.). DUE TO (b) Arteriosclerotic Heart Disease. DUE TO (c) Heart		INTERVAL BETWEEN ONSET AND DEATH 4 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-21-67 , 19 2-21 , 19 67 , that (I) (we) just saw the deceased alive on 2-21-67 , and that death occurred at 9:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED 2-22-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-25-67	23c. NAME OF CEMETERY OR CREMATORY Laytonsville Methodist	23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 2 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02316

CERTIFICATE OF DEATH

02312

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 5212 Marlyn Drive	
3. NAME OF DECEASED (Type or print) SAMUEL EXUM COBB		4. DATE OF DEATH Feb., 4, 19 67	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1902
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tech. Writer		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (County & State, or foreign country) Florida		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Samuel E. Cobb Sr.		16. MOTHER'S MAIDEN NAME Allene Fraleigh	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		18. SOCIAL SECURITY NO. 579-22-6332	
19. INFORMANT Mrs. Cornelia C. Cobb (Above)		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Coronary Occlusion DUE TO 4361 (b) 2. Arteriosclerosis, Coronary Arter DUE TO 10 years (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to 4 Feb, 1967 , that (I) (we) last saw the deceased alive on 19 Jan 1967 and that death occurred at 8:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Harry Horstman		22b. DATE SIGNED 2/4/67	
22c. PHYSICIAN'S NAME (Type) Harry Horstman		22d. ADDRESS 916 - 19th Street, N.W., Wash, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Feb. 6, 1967	
23c. NAME OF CEMETERY OR CREMATORY Oak Ridge		23d. LOCATION (City or town) (County) (State) Madison Florida	
24. FUNERAL DIRECTOR Joe. Sawley's Sons Inc. Wash. DC		25a. REC'D BY REGISTRAR DATE FEB 8 1967	
25b. REGISTRAR'S SIGNATURE Charles J. ...			

Dr. Ball, Med. Exam., notified and approved. JGS

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02...

CERTIFICATE OF DEATH

02313

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>4111 Phyllis Mill Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elmer's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>INEZ</u> First Middle Last				4 DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1967</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5/9/03</u>	
9 AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Mont. Co. Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>James B. Weeden</u>			
14 MOTHER'S MAIDEN NAME <u>Oppe Johnson</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16 SOCIAL SECURITY NO				17. INFORMANT <u>daughter</u> Address <u>above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Massive Inferior Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes with ketoacidosis</u>							19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>23 February, 1967</u> to <u>26 February 1967</u> that (I) (we) lost saw the deceased alive on <u>26 February 1967</u> , and that death occurred at <u>2:45 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Frederick S. Caldwell</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. CALDWELL</u>				22d. ADDRESS <u>707 Pine Rockville, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>JOHN T. RHINES COMPANY</u>				ADDRESS <u>3015 12TH ST. WASHINGTON, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>MAR 1 1967</u>		25b. REGISTRAR'S SIGNATURE	

02318

CERTIFICATE OF DEATH

02314

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 209 Water Street		d. STREET ADDRESS 209 Water Street	
3 NAME OF DECEASED (Type or print) JAMES WILLIAM COLLINS		4. DATE OF DEATH February 14, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 21, 1896
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR: Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Gardner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James William Collins		14. MOTHER'S MAIDEN NAME Mary Whalen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1		16. SOCIAL SECURITY NO 578-20-7602	
17. INFORMANT Florence Ruth Collins same item 2-life		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO 4201 (b) A.H.D. & Cardiomagn DUE TO Buil. Arteriosclerosis (c) Buil. Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Minutes Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tracheo-Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 2-14, 1967 , that (I) (we) last saw the deceased alive on 2-12, 1967 , and that death occurred at 1:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS 15 Russel Ave., Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/17/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR 1301 Rock. Rd. ADDRESS	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02319

CERTIFICATE OF DEATH

02315

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admjssion) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>6400 Stratford Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Frank B. Collins</u>		4 DATE OF DEATH <u>2-11-67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-16-1878</u>
9 AGE (In years last birthday) <u>88</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12 CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Peter B. Dick</u>		14 MOTHER'S MAIDEN NAME <u>Emily Shade</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>214-05-8562</u>	
17 INFORMANT <u>Georgia Williams daughter - same</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>berebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 year</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>Feb 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 10</u> , 19 <u>67</u> , and that death occurred at <u>2 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u>		22b. DATE SIGNED <u>Feb 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Ave, Chevy Chase Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2-14-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Greenwood Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Unger, W. Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>		25a REC'D BY REGISTRAR <u>FEB 17 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 of this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #4 Film # 2/20/67

02320

CERTIFICATE OF DEATH

02316

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e STREET ADDRESS <u>9715 Kingston Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Marie Concannon</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>February 10, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13 FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Maureen Concannon</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT <u>Mother</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple subdural and intracerebral hemorrhages</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>congenital hydrocephalus</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 19 <u>67</u> , to <u>2-10</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>2-10</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>William F. Colliton, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11 Feb 67</u>
22c. PHYSICIAN'S NAME (Type) <u>William F. Colliton, Jr., M.D.</u>		22d. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>Wm. J. Heeler Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it is to be removed, or removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
02321		02317	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5721 Grosvenor Lane Resmor Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 5338 Nebraska Ave. Grosvenor Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Azo Middle Barney Last Cott		4. DATE OF DEATH Month February Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Review Examiner-Frt. Sec. G.A.O.		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Cott		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW2		16. SOCIAL SECURITY NO. 577-42-9745	
17. INFORMANT Ottie Cott		Address 5338 Nebraska Ave. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Cardiovascular disease DUE TO (c) Paralysis agitans PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 HRS. 4 YRS. 11 YRS.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-23, 1953 to 2-23, 1967 , that (I) (we) last saw the deceased alive on 2-22, 1967 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE G. P. Quayle M.D.		22b. DATE SIGNED 2-23, 1967	
22c. PHYSICIAN'S NAME (Type) G. P. Quayle M.D.		22d. ADDRESS 1222 Biltmore St. N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 2/25/67	23c. NAME OF CEMETERY OR CREMATORY Ridge Park Cemetery	23d. LOCATION (City, town or county) (State) Marshall, Missouri
24. FUNERAL DIRECTOR The S.H. Hines Address 2901 14th St. Washington, D.C.		25a. REC'D BY REGISTRAR FEB 24 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02322

CERTIFICATE OF DEATH

02318

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>17 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN + HOSP</u>				d. STREET ADDRESS <u>7721 Eastern Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE ELIZABETH COWLES</u>				4. DATE OF DEATH Month Day Year <u>2 20 19 67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-02 67</u>		9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA</u>		11. BIRTHPLACE (County & State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS CARTER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE MARSHALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>579-44-4084</u>		17. INFORMANT <u>BERNICE STANSBURY (SISTER)</u> <u>CHARL 7719 EASTERN AVE. N.W. D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>5811 EXSANGUINATION</u> DUE TO (b) <u>RUPTURED ESOPHAGEAL VARICES</u> (c) <u>PORTAL VEIN OBSTRUCTION - HEPATIC FAILURE</u> DUE TO (d) <u>ASCITES</u> (e) <u>LAENNETT'S CIRRHOSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 HOURS</u> <u>2 WEEKS</u> <u>8 YEARS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MALNUTRITION</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 26, 1966</u> , to <u>FEB 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>FEB 19 1967</u> , and that death occurred at <u>3:24 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D.				22b. DATE SIGNED <u>2/20/67</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>	
22d. ADDRESS <u>7733 PARK MEADE RD WASHINGTON DC 20012</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Collins Funeral Home</u>		ADDRESS <u>3821 14th St. N.W. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles J. ...</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	
DATE <u>FEB 23 1967</u>							

STAT. 5-23-67 FT LINGON CAMPBRY BLADENSBURG, MARYLAND.

03770

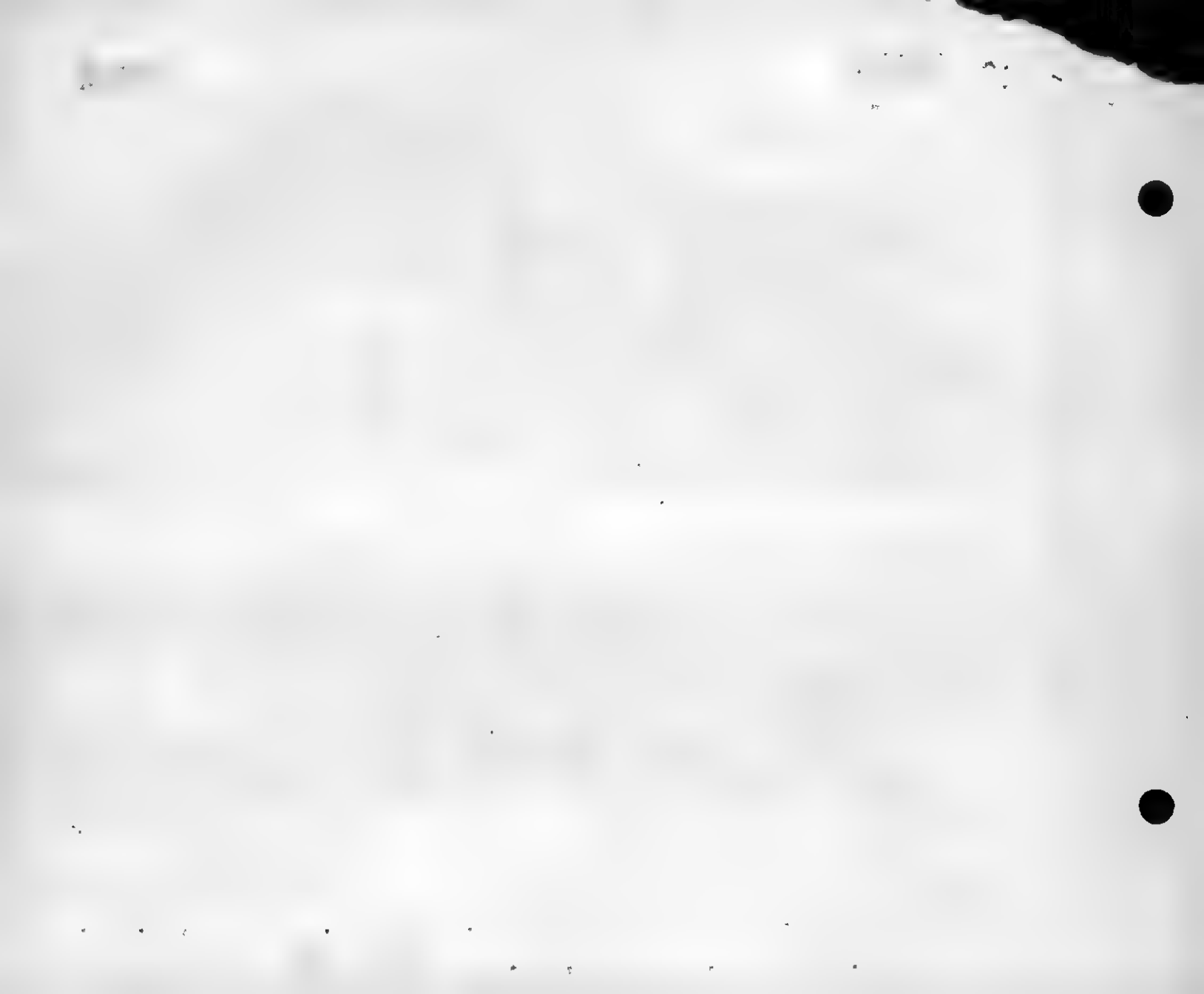
CERTIFICATE OF DEATH

03766

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 44 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS (No Street Address)	
3. NAME OF DECEASED (Type or print) First Ethel Middle Thelma Last Cox		4. DATE OF DEATH Month February Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 April 1908
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hayes Rowe		14. MOTHER'S MAIDEN NAME Disie Steele	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Records		18. ADDRESS The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bacterial Sepsis 2013 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute renal failure DUE TO (c) Acute myelogenous leukemia			INTERVAL BETWEEN ONSET AND DEATH 3 days 8 days 12 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholecystitis with cholelithiasis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 January, 19 67 to 25 February 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 25 February 19 67 , and that death occurred on 11:00M , from causes and on the date stated above.			
22a. SIGNATURE Leonard H. Brubaker		22b. DATE SIGNED 2/25/67	
22c. PHYSICIAN'S NAME (Type) Leonard H. Brubaker, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-1-67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Cemetery, Bluewell, W. Va.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.		25. REC'D BY REGISTRAR MAR 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02323

CERTIFICATE OF DEATH

02319

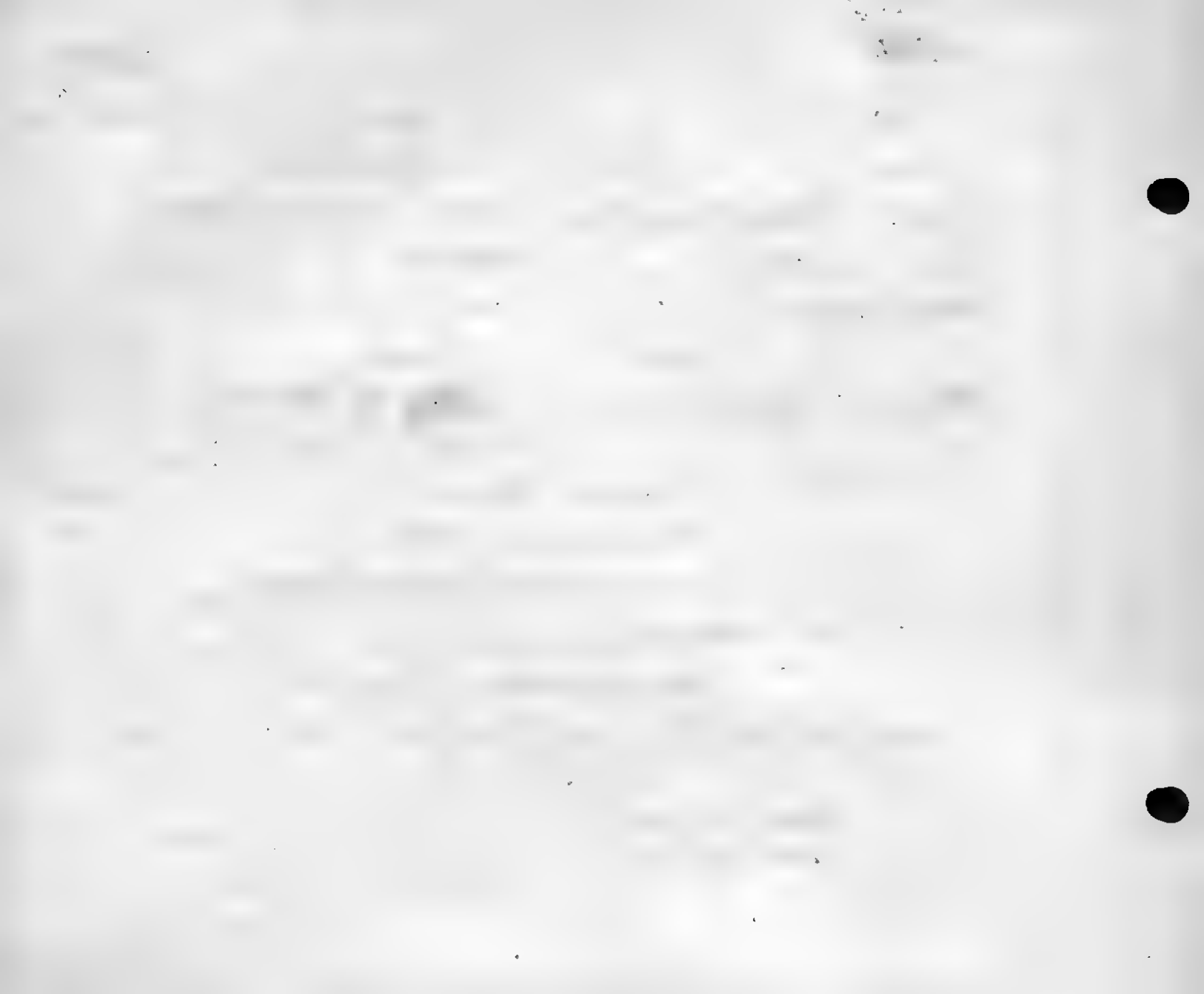
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>23 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San & Hosp</i>		d. STREET ADDRESS <i>7717 GREENWOOD AVE</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Dorothy Elizabeth Cozadd</i>		4. DATE OF DEATH Month Day Year <i>2 - 18 19 67</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-27-00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>PENNA</i>		12. CITIZEN OF WHAT COUNTRY? <i>AMERICA</i>	
13. FATHER'S NAME <i>John BOUARD</i>		14. MOTHER'S MAIDEN NAME <i>Zella Ramsdall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>177-04-3584D</i>	
17. INFORMANT <i>Christ Ann Mann</i>		Address <i>13209 Justice Rd Rockville, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL FAILURE</i> DUE TO (b) <i>CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION</i> DUE TO (c) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>8 weeks</i> <i>8 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ASTHMA, EMPHYSEMA, DIABETES MELLITUS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>JUNE, 1958</i> , to <i>FEB. 18, 1967</i> , that (II) (we) last saw the deceased alive on <i>FEB. 17, 1967</i> , and that death occurred at <i>7:45 AM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>Robert K. Krichmar</i>		22b. DATE SIGNED <i>FEB. 18, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT K. KRICHMAR</i>		22d. ADDRESS <i>7733 ALASKA AVENUE N.W. WASHINGTON DC 20012</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/20/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rockville</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>		25a. REC'D BY REGISTRAR <i>DATE FEB 21 1967</i>	
ADDRESS <i>Funeral Home-1331 Rockville Pike Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1 02324</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>02320</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			d. STREET ADDRESS <u>7010 - Greenvale Parkway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Garden Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>V</u> Last <u>CROCKETT</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>10</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept 28, 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Charles E Vernon -</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mc DONALD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records Kensington Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia.</u> 4500 DUE TO (b) <u>Malacia Generalized -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>arterio Sclerosis Generalized - severe -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 years</u> <u>years.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Hip -</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell out of chair - at nursing home</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:00</u> <u>1/31</u> <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home -</u>		20f. (City or town) (County) (State) <u>Kensington - Mont. Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>2/10/67</u>		23. DATE THEREOF <u>Feb 13, 1967</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23c. LOCATION (City, town or county) (State) <u>Suitland Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		26. CHIEF MEDICAL EXAMINER SIGNATURE <u>John G. Ball</u> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02325

CERTIFICATE OF DEATH

02321

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE South Carolina b. COUNTY Richmond		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 142 Days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d STREET ADDRESS 318 South Edisto Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Ira Middle Pressley Last Crowder			4 DATE OF DEATH Month February Day 18 Year 19 67		
5 SEX Male	6 COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 29, 1894	9 AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months 18 Days 19 Hours 67 Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Fairfield South Carolina	
13. FATHER'S NAME Robert Franklin Crowder			14. MOTHER'S MAIDEN NAME Lulu Barrett		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO 532 14 8662		17 INFORMANT 325 S. Edisto Ave. Mrs W.T. Peters Columbia, SC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic adenocarcinoma associated with malignant lymphoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 11 , 19 66 , to Feb. 18 , 19 67 that (I) (we) last saw the deceased alive on Feb. 18, 1967 at 8:20 PM , from causes and on the date stated above					
22a SIGNATURE 			22b. DATE SIGNED 20 FEB 1967		
22c PHYSICIAN'S NAME (Type) D.R. FOREMAN, LT MC USN			22d ADDRESS Naval Hospital, Bethesda, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 2-21-67		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
24 FUNERAL DIRECTOR R.A. PUMPHREY, 7557 Wisconsin Ave, Bethesda, Md.		25a RECD BY REGISTRAR DATE FEB 23 1967		25b REGISTRAR'S SIGNATURE 	
23d LOCATION (City or Town) (County) (State) Columbia, South Carolina					

02326

CERTIFICATE OF DEATH

02322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Uheaton Nursing Home</u>		d. STREET ADDRESS <u>11901 George Ave. 12422 Melody Turn</u>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>N.</u> Last <u>Cullen</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during last 12 months) <u>Resident Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Appt. Building</u>	9. AGE (In years last birthday) <u>61</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Singley</u>		14. MOTHER'S MAIDEN NAME <u>Eva Betham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>256 18 4009</u>	
17. INFORMANT <u>Watson R. Edgin</u>		Address <u>Same as #2 (son)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF PANCREAS</u> 157A DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>March 1965</u> <u>2-20-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/24, 1966</u> , to <u>2/20, 1967</u> , that (I) (we) last saw the deceased alive on <u>18 FEB 1967</u> , and that death occurred at <u>10:4 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Goetz</u>		22b. DATE SIGNED <u>2/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOOZH MD</u>		22d. ADDRESS <u>2309 Shorefield Uheaton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City or town) (County) (State) <u>Colmar Manor P.G. Md.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 1967</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Walter E. Goetz</u>	

02327

CERTIFICATE OF DEATH

02323

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>4318 Rowalt Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Helen Mary Cunningham</u>		4. DATE OF DEATH <u>2-8-1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-98</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR <u>2</u> Months <u>8</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife Own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hastings, Penna.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Patrick Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Yahner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>208-05-9074</u>	
17. INFORMANT <u>Mr. Hugh Cunningham</u>		Address <u>4318 Rowalt Drive College Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory distress</u> DUE TO <u>HEART FAILURE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRIMARY ADENOCARCINOMA OF GUARD</u> (c) <u>with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pylonephritis with uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not White <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>67</u> , to <u>2-8</u> , 19 <u>67</u> , that (I) (was) last saw the deceased alive on <u>2-8</u> , 19 <u>67</u> , and that death occurred at <u>6:00 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>John L. Ford</u>		22b. DATE SIGNED <u>2-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD MD</u>		22d. ADDRESS <u>831 UNIVERSITY BLVD E. SILVER SPRING MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Feb 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Benedict Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Carrolltown, Penna.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		DATE <u>FEB 14 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02324

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TALOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S. S.</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sant. & Hospital</u>				d. STREET ADDRESS <u>8717 Plymouth St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Franklin</u> Last <u>Daniels</u>				4 DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/9/16</u>	9 AGE (In years last birthday) <u>50</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11 BIRTHPLACE (State or foreign country) <u>Alex. Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>				14 MOTHER'S MAIDEN NAME <u>Unknown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16 SOCIAL SECURITY NO <u>Yes</u>		17 INFORMANT <u>MRS MARGARET DANIELS - Wife</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery heart disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.				22. DATE SIGNED <u>Feb. 9, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <u>Charles Judge</u> Address (Street, City, State or county) <u>Charles Judge</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. ADDRESS <u>Clark E. Wiso & Co. 434 Georgia Ave. Silver Spring, Md.</u>				DATE <u>FEB 14 1967</u>			

02329

CERTIFICATE OF DEATH

02325

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN b. <u>36 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		d. STREET ADDRESS <u>313 DENNIS AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>Marie</u> Last <u>DAY</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>5</u> Year <u>19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-88</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> M.n. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry M. Biggs</u>		14. MOTHER'S MAIDEN NAME <u>Alice Bremermann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-28-0971-A</u>	
17. INFORMANT <u>Mrs. John Rogers</u>		Address <u>313 Dennis Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute diaphragmatic myocardial infarct</u> (c) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>67</u> , to <u>Feb. 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5</u> , 19 <u>67</u> , and that death occurred at <u>7:45 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u>		22b. DATE SIGNED <u>2/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>		22d. ADDRESS <u>345 UNIVERSITY BLVD, WEST</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>February 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ht. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter & Son</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>		DATE <u>FEB 9 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

■ A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02330

CERTIFICATE OF DEATH

02326

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN TB 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 12309 Centerhill Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) James Thomas Dean Sr.				4 DATE OF DEATH Month February Day 26 Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH June 3, 1919	
9 AGE (In years last birthday) 47 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Installer		10b. KIND OF BUSINESS OR INDUSTRY Western Electric		11 BIRTHPLACE (County & State, or foreign country) D.C. Washington, America	
13 FATHER'S NAME William Dean				14. MOTHER'S MAIDEN NAME Mary Matthews			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW2 Navy		16 SOCIAL SECURITY NO. 577-12-0068		17 INFORMANT Mrs. Ann D. Dean Address 12309 Centerhill St. Wheaton, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease - Infarction DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO Coronary Artery Disease (c) Coronary Artery Disease						INTERVAL BETWEEN ONSET AND DEATH 300 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1967 to March 2, 1967 , that (I) (we) last saw the deceased alive on March 2, 1967 , and that death occurred at 11:30 AM , from causes and on the date stated above							
22a. SIGNATURE Arthur H. H. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-27-67	
22c. PHYSICIAN'S NAME (Type) Arthur H. H. M.D.				22d. ADDRESS 1025 E. Pk. St. Springfield, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF March 1, 1967		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Glen Carter, 8434 Georgia Avenue, Silver Spring, Md.				25a REC'D BY REGISTRAR DATE MAR 2 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

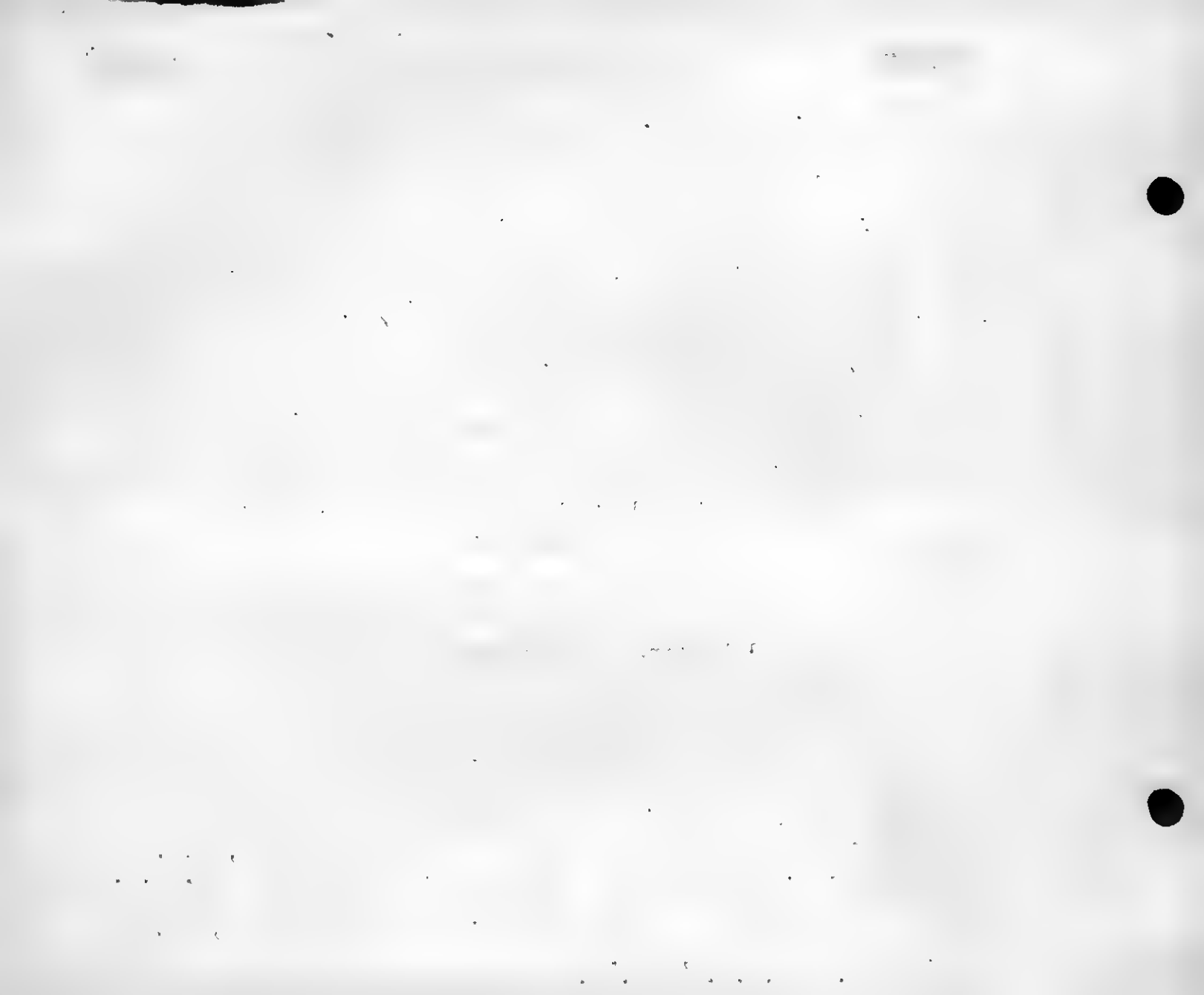
02331

CERTIFICATE OF DEATH

02327

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If the permit is to be removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7308-Britannia Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph H. Dear</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1922</u>
9. AGE (in years last birthday) <u>44</u> yrs		10. FUND 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Publisher</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Dear Publications New Jersey</u>	
11. BIRTHPLACE (County & State or foreign country) <u>D.C.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Albert Dear</u>		14. MOTHER'S MAIDEN NAME <u>Mary Eddy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Ann Dear/sister. He above.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrapulmonary hemorrhage with asphyxia</u> 410A CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary hypertension</u> (c) <u>Advanced Chronic Rheumatic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>months</u> <u>30 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Guillain-Barre Syndrome-- 2 weeks.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6</u> , 19 <u>66</u> , to <u>Feb 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> , 19 <u>67</u> , and that death occurred at <u>1:42</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>J. Blaine Fitzgerald</u> M.D.		22b. DATE SIGNED <u>2/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. Blaine Fitzgerald</u>		22d. ADDRESS <u>Washington, D.C.</u> <u>8218 Wisconsin Ave. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



02332

CERTIFICATE OF DEATH

02328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>10607 St. Paul St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John deBettencourt</u>		4. DATE OF DEATH <u>2-9-67</u>	
5. SEX <u>M</u>	6. CO. OR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-14</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>9</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Special Agent - FBI - U.S. govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph S. deBettencourt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kelliker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Brother Francis</u>	
17. INFORMANT <u>Brother Francis</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis, generalized, purulent</u> DUE TO (b) <u>Perforated duodenal ulcer</u> DUE TO (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Purulent tracheo-bronchitis with bronchopneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> , 1967, to <u>2-9-</u> , 1967, that (I) (we) last saw the deceased alive on <u>2-8-</u> 1967, and that death occurred at <u>9:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Linwood H. Johnson, Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2-9-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Linwood H. Johnson, Jr.</u>		22d. ADDRESS <u>4405 East West Highway, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Not listed cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>CLIFFORD FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James Judge</u>

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02333 CERTIFICATE OF DEATH 02329

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>40 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>830 Gist Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>830 Gist Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRY ANDERSON DEEBLE</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14 1883</u>	9. AGE (In years last birthday) <u>83 yrs</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Dept Woodward & Lothrop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Silas Wright Deeble</u>		14. MOTHER'S MAIDEN NAME <u>Anne Macanally</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-5942-A</u>		17. INFORMANT <u>Eleanor Deeble</u> Address <u>830 Gist Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism; Chr. Pyelonephritis</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1953</u> to <u>Feb 10, 1967</u> that (I) (we) last saw the deceased alive on <u>Feb 10, 1967</u> , and that death occurred at <u>5:10 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Warren B. Burch</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>WARREN B. BURCH</u>		22d. ADDRESS <u>405 A St S.E. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d. LOCATION (City, town or county)		23e. (State)		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. Glen Carter</u>		ADDRESS <u>4040 Ga. Avenue</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		DATE <u>FEB 16 1967</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02334

02330

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 7 E MELBOURNE AVE	
3 NAME OF DECEASED (Type or print) First CLARA I. Middle XXXXXXXXXX Last Delaney		4 DATE OF DEATH Month 2 Day 8 Year 1967	
5 SEX F	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 14, 1878
9 AGE (in years last birthday) 88 yrs		10 IF UNDER 1 YEAR Months 8 Days 19 Hours 67 Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12 CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME XXXXXXXXXX Nicholas Laner		14 MOTHER'S MAIDEN NAME XXXXXXXXX Elizabeth Reis	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-46-8867	
17 INFORMANT Laura D. Jones		Address 7 E. Melbourne Avenue Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of cecum with metastases 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between ONSET AND DEATH 6 months			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
21c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	21d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	21f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1958 to Feb 8, 1957 , that (I) (we) lost saw the deceased alive on Feb 8, 1957 , and that death occurred at 10:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Blaine H. ETC		22b. DATE SIGNED Feb 8, 1967	
22c. PHYSICIAN'S NAME (Type) BLAINE H. ETC		22d. ADDRESS 1641 Colomille Rd Silver Spring, Md	
23a BURIAL, CREMATION, REMOVAL (specify) Burial	23b. DATE THEREOF Feb 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24 FUNERAL DIRECTOR C. Glen Garter Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02335

CERTIFICATE OF DEATH

02331

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN lb 1 month		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 9705 Nassau Lane	
3 NAME OF DECEASED (Type or print) Eugene Pascal De Vouges		4. DATE OF DEATH Month February Day 17 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1886	9. AGE (in years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Savage, Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Alphonse De Vouges		14 MOTHER'S MAIDEN NAME Teresa O'Farrell	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-46-3563		17 INFORMANT Address Mrs. Anita Kramer, 9705 Nassau La., S.S., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis (c) Unknown					INTERVAL BETWEEN ONSET AND DEATH 36 hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1965 to 17 Feb., 1967 , that (I) (we) last saw the deceased alive on Feb 16 , 1967, and that death occurred at 1:30 P.M. from causes and on the date stated above.					
22a. SIGNATURE George Sharpe		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Feb. 18, 1967	
22c. PHYSICIAN'S NAME (Type) George Sharpe, M.D.		22d. ADDRESS 10,400 Conn Ave., Wheaton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/20/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland	(County)	(State) Md.
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc., 8434 Georgia Ave.,		ADDRESS S.S. Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1967	25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02336

CERTIFICATE OF DEATH

02332

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>2 hr. 23 min</u>		d. STREET ADDRESS <u>2211 University Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Di Pietro</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/16/67</u>
9. AGE (In years last birthday) <u>2</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Di Pietro</u>		14. MOTHER'S MAIDEN NAME <u>Patricia McCoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frank Di Pietro</u>		Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Anoxia</u>			
DUE TO <u>7645</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <u>Prematurity</u>			
DUE TO <u>Neonatal Lactatosis</u>			
(c)			
INTERVAL BETWEEN ONSET AND DEATH			
(a) <u>1 mm</u>			
(b) <u>1 mm</u>			
(c) <u>1 mm</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> , 19 <u>67</u> , to <u>2/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> , 19 <u>67</u> , and that death occurred at <u>2:23 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Melvyn A. Shapiro</u> M.D.		22b. DATE SIGNED <u>2/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Melvyn A. Shapiro</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>Feb 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

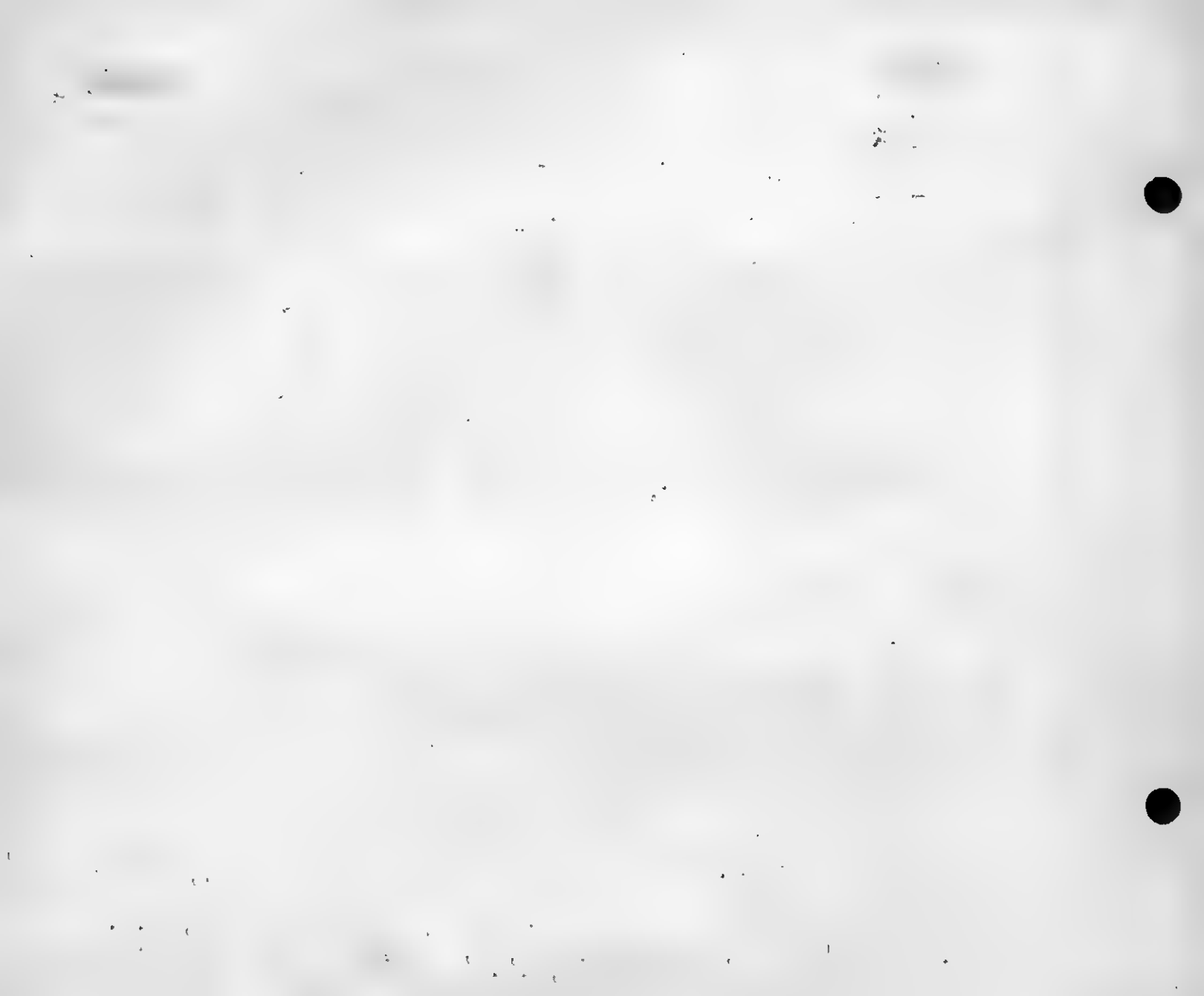
Item #2a,b,c & d form #0486 3/7/67 pc

02337

CERTIFICATE OF DEATH

02333

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Resident before admission) a STATE <u>Maryland</u> D.C. b COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c LENGTH OF STAY IN 1b <u>746 51/2 cs. 23 days</u>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington/ Washington, D.C.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d STREET ADDRESS <u>3420 16th St. N.W.</u> <u>3000 McComas Avenue</u>			
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Maud</u> Last <u>Douglas</u>				4 DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 29-1876</u>	9 AGE (In years last birthday) <u>90</u> yrs	10 IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>14</u> Min <u>19</u>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Rosaryville Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joseph R. Douglas</u>				14 MOTHER'S MAIDEN NAME <u>(Unknown) Smallwood</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>---</u>		17 INFORMANT <u>Nursing Home Records</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4300</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>10 yrs</u> DUE TO (b) <u>10 yrs</u> DUE TO (c) <u>10 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASHD</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2-22-65</u>		20f (City or town) (County) (State) <u>2-24-67</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-22-1965</u> to <u>2-24-1967</u> , that (I) (we) last saw the deceased alive on <u>2-22-1967</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.							
22a SIGNATURE <u>G. F. Sengstack M.D.</u>				22b DATE SIGNED <u>2-24-67</u>		22c PHYSICIAN'S NAME (Type) <u>George F. Sengstack</u>	
22d ADDRESS <u>9241 Columbia Blvd.,</u>				22e CITY OR TOWN <u>Silver Spring, Maryland</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>2/27/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24 FUNERAL DIRECTOR <u>Jos. Gawler's Sons, 5130 Wis. Ave. NW,</u>				25a REC'D BY REGISTRAR <u>DATE MAR 1 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
02338					CERTIFICATE OF DEATH					02334														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 37 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 707 Beaverbrook Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Gerald			First James			Middle Doyle			Last Doyle			4. DATE OF DEATH Month February Day 11 Year 19 67												
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 May 1914			9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zoning Examiner					10b. KIND OF BUSINESS OR INDUSTRY Municipal Government					11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME John J. Doyle					14. MOTHER'S MAIDEN NAME Julia M. Fitzgerald					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 218-26-1845					17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 2091 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Chronic Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe coronary atherosclerosis										INTERVAL BETWEEN ONSET AND DEATH 10 days 40 months														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that he (this hospital) attended the deceased from 5 January, 19 67 to 11 February 19 67 , that he (we) last saw the deceased alive on 11 February 19 67 , and that death occurred at 5:12 M. from the causes and on the date stated above.																								
22a. SIGNATURE <i>I. David Goldman</i> M.O.										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED 11 February 1967									
22c. PHYSICIAN'S NAME (Type) I. David Goldman, MD										22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 2/15/1967					23c. NAME OF CEMETERY OR CREMATORY New Cathedral					23d. LOCATION (City, town or county) (State) Baltimore, Md.									
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.										25a. REC'D BY REGISTRAR FEB 14 1967					25b. REGISTRAR'S SIGNATURE									



02339

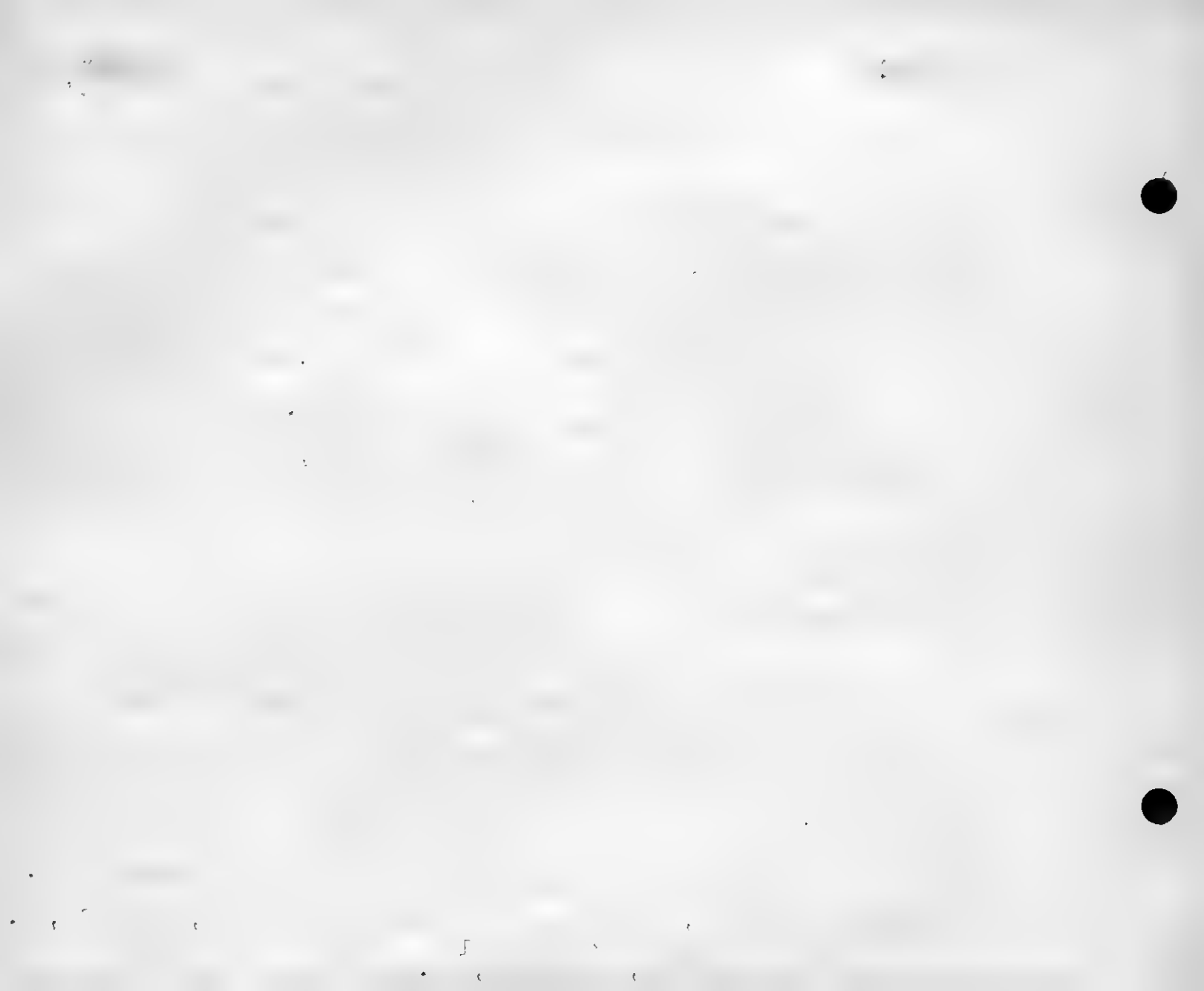
CERTIFICATE OF DEATH

02335

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 17 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. STREET ADDRESS 6928 Ruskin Street	
3. NAME OF DECEASED (Type or print) First Middle Last Michael James Dunaway		4. DATE OF DEATH Month Day Year February 3 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 January 1954
9. AGE (In years last birthday) 13 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Virginia (Lynchburg)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter J. Dunaway		14. MOTHER'S MAIDEN NAME Christine J. Saunders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho/Pneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchiectasis -- Cerebral edema DUE TO (c) Cystic Fibrosis of pancreas		INTERVAL BETWEEN ONSET AND DEATH 2 Days 24 Hours 3 Years 13 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 January, 1967, to 3 February, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 February 1967 , and that death occurred at 5:30PM , from causes and on the date stated above.			
22a. SIGNATURE Georges Peter		22b. DATE SIGNED 4 February 1967	
22c. PHYSICIAN'S NAME (Type) Georges Peter, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF February 6, 67	23c. NAME OF CEMETERY OR CREMATORY Falling River Bapt Ch Brookneal, Campbell, Va.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Henderson Funeral Home, Brookneal, Va.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02340

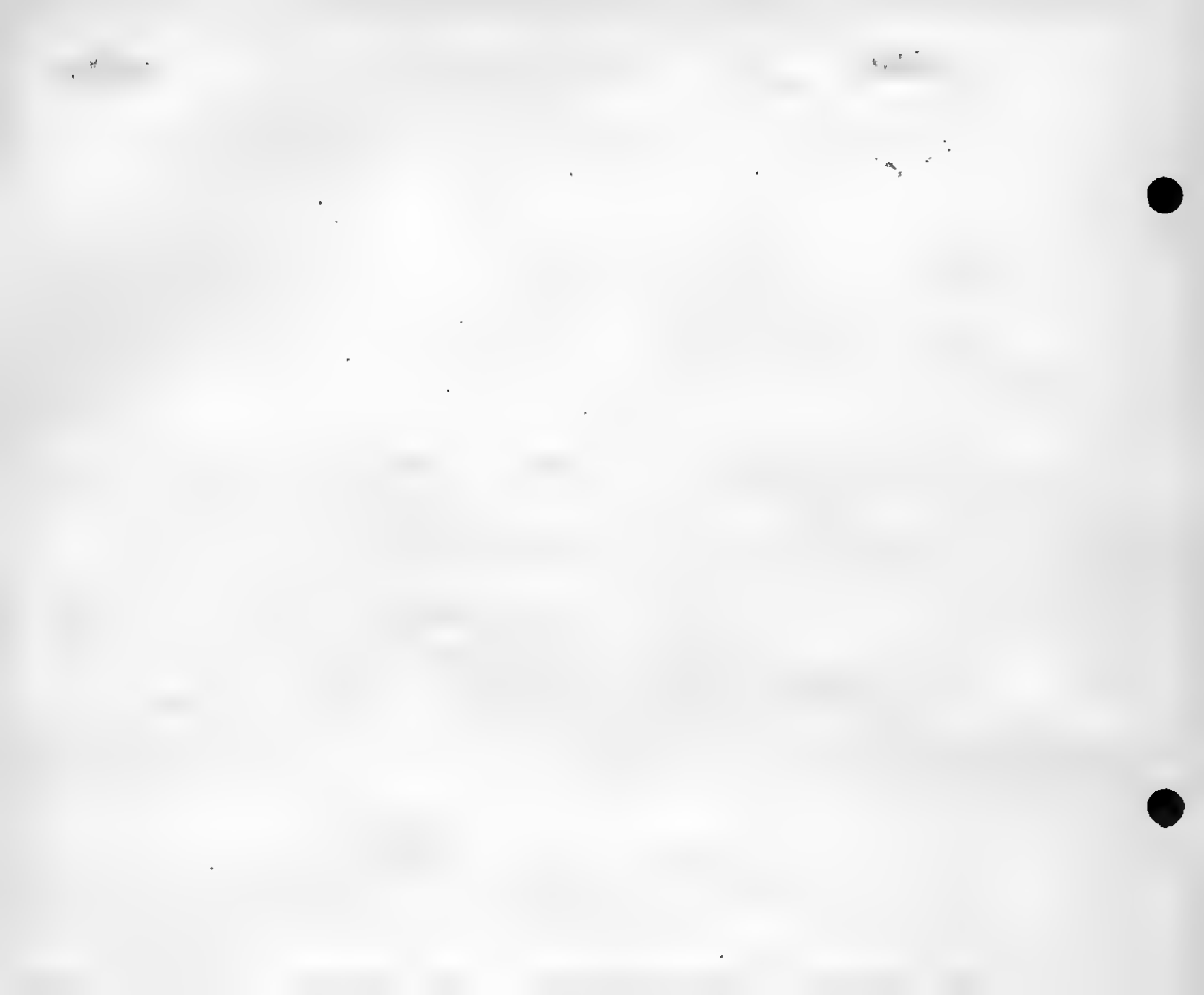
CERTIFICATE OF DEATH

02336

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>220 N. Grandin Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Henry</u> Last <u>Surst</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/95</u>		9. AGE (in years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry</u>				14. MOTHER'S MAIDEN NAME <u>Caroline</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05154A</u>		17. INFORMANT <u>Dr.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>7 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>24 Jan</u> 19 <u>67</u> , and that death occurred at <u>9:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John W. Wyman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Wyman</u>				22d. ADDRESS <u>7801 Norfolk Ave. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or town) (County) (State) <u>Bladensburg Prince Georges Md</u>	
24. FUNERAL DIRECTOR <u>Ernest G. Gartner</u>				25a. REC'D BY REGISTRAR <u>James J. Judge</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02341

CERTIFICATE OF DEATH

02337

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>28 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12621 New Hampshire Avenue</u>		d STREET ADDRESS <u>12621 New Hampshire Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Burton</u> Last <u>Dustin</u>		4 DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 27, 1890</u>
9 AGE (In years Last birthday) yrs <u>76</u>		10 IF UNDER 1 YEAR Months <u>12</u> Days <u>24</u> Hours <u>12</u> Min <u>00</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>D. C. Govt.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Montgomery County, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Clinton Dustin</u>		14 MOTHER'S MAIDEN NAME <u>Virginia Burton</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>577-03-8891</u>	
17 INFORMANT <u>Emma G. Dustin</u>		Address <u>12621 New Hampshire Ave. Silver Spring, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>acute congestive failure</u> DUE TO (c) <u>Progressive Parkinson's disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-24 hrs</u> <u>12-24 hrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized & cerebral arteriosclerosis - Chronic</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Syncope</u>		20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (1) this hospital attended the deceased from <u>Nov 18, 1965</u> to <u>Feb 18, 1967</u> ; that (2) (we) last saw the deceased alive on <u>Feb 14, 1967</u> , and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above	
22a SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>2-18-67</u>	
22c PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>		22d ADDRESS <u>BURTONSVILLE, MD.</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Feb 22, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24 FUNERAL DIRECTOR <u>John B. Thomas</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02342						02338					
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
Montgomery MARYLAND						Virginia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Bethesda						Norfolk					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
The Clinical Center, Bethesda, Md. 20014						1110 Bolling Avenue					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last Dave Warren Edwards						Month Day Year February 22 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White				30 May 1954		12 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Student				--		Virginia				USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Jay Nash Edwards						Billie Warren					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No --				None		The Medical Records The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia											
2043 DUE TO organisms											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Perirectal abscesses, multiple (gram negative)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11 June, 1966, to 22 Feb., 1967, that (we) last saw the deceased alive on 22 February 1967, and that death occurred at 2:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Myron J. Levin						22b. DATE SIGNED 23 February 1967					
22c. PHYSICIAN'S NAME (Type) Myron J. Levin, MD						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)	
Removal				2-23-1967		Norfolk, Va.					
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 27 1967					



02343

CERTIFICATE OF DEATH

02339

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville (Lewisdale)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>6919 24th Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Ruth OPAL Edwards</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) <u>Ret. Bindery Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	9 AGE (In years lost birthday) <u>66</u> yrs
13. FATHER'S NAME <u>FRANKLIN Lindsay</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>223-10-0611</u>	
17. INFORMANT <u>Patient's Chart</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A. America</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Cerebrovascular arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/3, 1967</u> to <u>2/25, 1967</u> that (I) (we) lost saw the deceased alive on <u>2/25, 1967</u> and that death occurred at <u>5:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Boris Ruben</u>		22b. DATE SIGNED <u>2/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RUBEN, MD</u>		22d. ADDRESS <u>1019 Univ Blvd Wash</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1967</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02340

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Sumner</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Sumner</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4509 Sangamore Rd.</u>			d. STREET ADDRESS <u>4509 Sangamore Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Stephen S. Edwards</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1967</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1940</u>	9. AGE (In years last birthday) <u>26</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACT BY ENLISTED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US ARMY</u>		11. BIRTHPLACE (State or foreign country) <u>RHODE ISLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Joseph T. EDWARDS</u> <u>J. T. Edwards</u>		
14. MOTHER'S MAIDEN NAME <u>Marian Sherman</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>AUG</u>		
16. SOCIAL SECURITY NO. <u>037-26-5735</u>			17. INFORMANT <u>Joyce Edwards-407 Prospect St</u> Address <u>Woonsocket R.I.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head</u> DUE TO (b) <u>776X</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) <u>Shot. Self with Pistol - in Head</u>			
20c. TIME OF INJURY Month Day, Year Hour a.m. <u>5:06</u> <u>7/16</u> <u>1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>apartment</u>	20f. (City or town) <u>Fort Sumner, Md.</u>	(County) <u> </u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D.		22. DATE SIGNED <u>2/16/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u> </u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>BURIAL</u>	23b. DATE OF INTERMENT <u>7/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNK</u>		23d. LOCATION (City or town) (County) (State) <u>SWAN POINT, Prince Georges Co, Md.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Washington, D.C.</u>		ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u> </u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>
DATE <u>FEB 20 1967</u>					

SPOUSE: Joyce Edwards - 407 Prospect St., Woonsocket, RI

02345

CERTIFICATE OF DEATH

02341

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN TB <u>23 Mos.</u>	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges County Hospital</u>			d. STREET ADDRESS <u>4000 Slocum Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ANNA EGGENBERGER</u>			4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19 1916</u>		9. AGE (In years last birthday) <u>51 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Odell, Illinois</u>	
13. FATHER'S NAME <u>Gallus Eggenberger</u>			14. MOTHER'S MAIDEN NAME <u>Agatha Hilti</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Neice</u> <u>Same as Item 2.</u> <u>Mrs. Werner P. Meyer</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 4500 DUE TO (b) <u>arterio sclerosis</u> DUE TO (c) <u></u>					INTERVA. BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1965</u> to <u>14 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 Feb</u> , 19 <u>65</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>W. S. Murphy</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 Feb 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. S. Murphy</u>		22d. ADDRESS <u>615 W. Montgomery Ave.</u> <u>Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial-transit</u>	<u>2-15-67</u>	<u>Odell Union Cemetery</u>		<u>Odell, Illinois</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

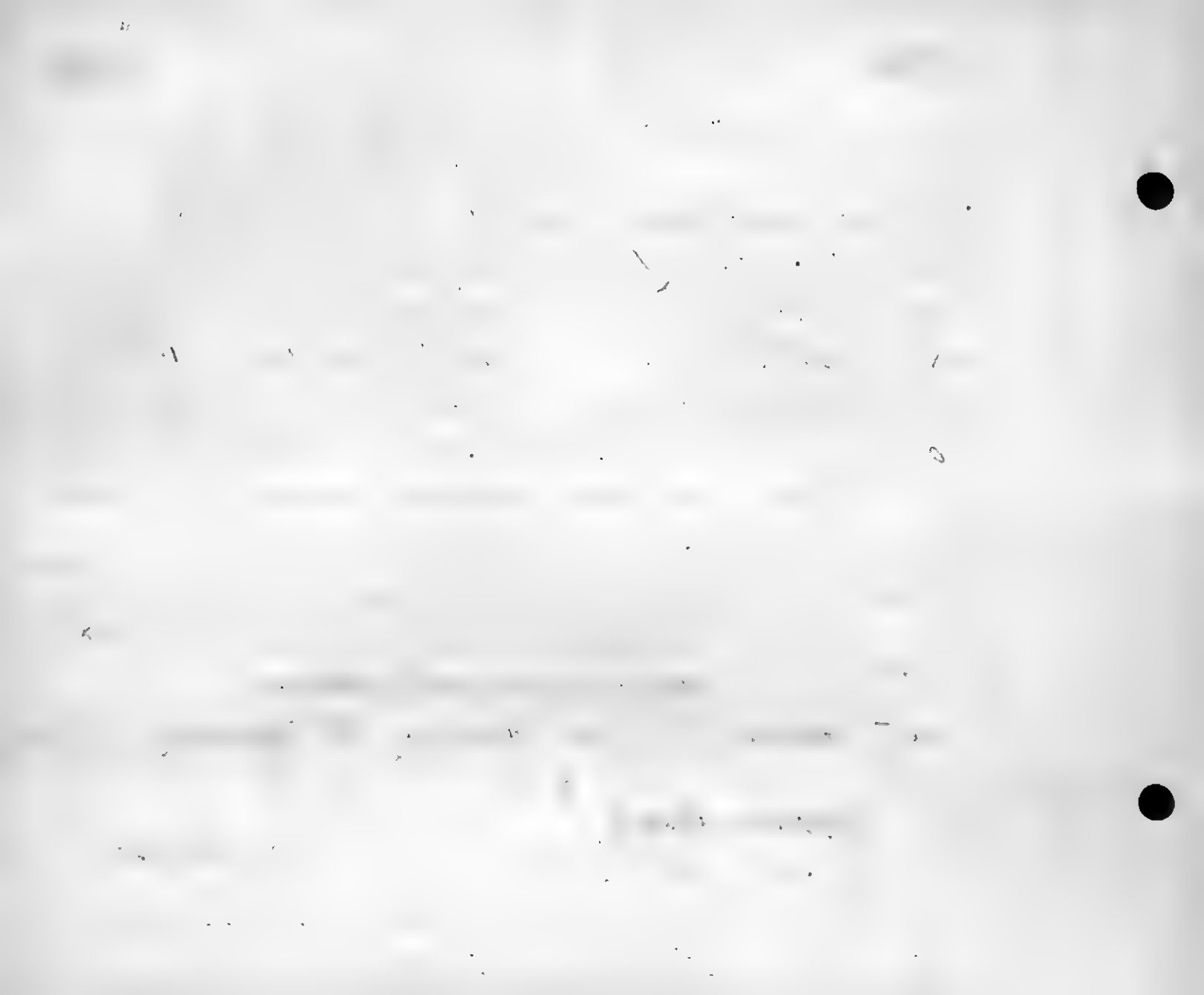
VR AISM (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02346

02342

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>M</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN ID <u>17 days</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>							
3. NAME OF DECEASED (Type or print) <u>Harold Anton Eggers</u>				4. DATE OF DEATH <u>2-27</u> 19 <u>67</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-14</u>					
9. AGE (In years last birthday) <u>52</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>SCIENCE</u>		11. BIRTHPLACE (State or foreign country) <u>North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Christopher Eggers</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Grunhagen</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-09-2792</u>							
17. INFORMANT <u>Catherine Eggers</u> Address <u>Silver Spring, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM, MASSIVE, BILATERAL</u> 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>PHLEBOTHROMOSIS OF LEG VEINS</u> DUE TO (c) <u>FRACTURES</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> 18 days			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head on collision with another car.</u>							
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. Feb 8 1967</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				20f. (City or town) (County) (State) <u>PA State College. Penna</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>2/27/67</u>							
EXAMINER'S NAME (Type) <u>John G. Ball</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 2, 1967</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>							
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>							
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				DATE <u>MAR 3 1967</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02347

CERTIFICATE OF DEATH

02343

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Maryland</u>		d. STREET ADDRESS <u>400 South Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>Denise</u> Last <u>Esworthy</u>		4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 December 1956</u>
9. AGE (In years last birthday) <u>10</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Albert D. Esworthy, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Dorothy Grim</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest secondary to pulmonary insufficiency</u> DUE TO (b) <u>Bronchopneumonia and bronchiectasis</u> DUE TO (c) <u>Cystic fibrosis of pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>2 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (it) (this hospital) attended the deceased from <u>6 February, 19 67</u> , to <u>24 February 19 67</u> , that (it) (we) last saw the deceased alive on <u>24 February 19 67</u> , and that death occurred at <u>1:50</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Georges Peter</u>		22b. DATE SIGNED <u>24 February 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Georges Peter, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/25/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

02348

CERTIFICATE OF DEATH

02344

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut- o. STATE <u>Maryland</u> b. COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY IN lb <u>6 DAYS</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTOMAC</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & HOSPITAL</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f STREET ADDRESS <u>POTOMAC MANOR Nursing Home</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM (None) EWING</u>		4 DATE OF DEATH Month Day Year <u>FEBRUARY 15 1967</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7-2-85</u>	9 AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>SCOTLAND</u>	
12 CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>		13 FATHER'S NAME <u>CHARLES C. EWING</u>		14 MOTHER'S MAIDEN NAME <u>HARRIET SHENEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWI</u>		16 SOCIAL SECURITY NO <u>374-22-5735</u>		17. INFORMANT Address <u>Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/9, 1967</u> , to <u>2/15, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/15, 1967</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above					
22a SIGNATURE <u>Boris Rabkin</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <u>2/16/67</u>	
22c PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d ADDRESS <u>1019 Union Road E</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Feb. 20, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>		
24 FUNERAL DIRECTOR <u>William Walters Washington, D.C. 20012</u>		25a RECD BY REGISTRAR DATE <u>FEB 20 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67



02349

CERTIFICATE OF DEATH

02345

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN b 8days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. San. & Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2521 ROSS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF Emanuel (Type or print)		4. DATE OF DEATH FEBRUARY 28 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 4, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS FALK		14. MOTHER'S MAIDEN NAME RACHEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213 32 7749	
17. INFORMANT WIFE		Address AS ABOVE-d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 64 , to 2-28 , 19 67 , that (I) (we) last saw the deceased alive on 2-28 , 19 67 , and that death occurred at 11:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Abraham W. Danish M.D.		22b. DATE SIGNED 3-1-67	
22c. PHYSICIAN'S NAME (Type) ABRAHAM W. DANISH		22d. ADDRESS 1106 SPRING ST. S.S. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-2-67	
23c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS-WASHINGTON DC		25a. REC'D BY REGISTRAR DATE MAR 3 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02350

CERTIFICATE OF DEATH

02346

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5404 Huntington Parkway		d. STREET ADDRESS 5404 Huntington Parkway	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH S. FARIS		4. DATE OF DEATH Month Day Year Feb. 3, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1897
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edward Martin Sheldon		14. MOTHER'S MAIDEN NAME Annie Armstrong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Wm. B. Looney		Address Charlottesville, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Unintentional asphyxiation 11301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Concurrent asphyxiation DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/20/66 , 19 66 , to 2/3/67 , 19 67 , that (I) (we) last saw the deceased alive on Jan 15 , 19 67 , and that death occurred at 8 A M. from causes on and on the date stated above.			
22a. SIGNATURE Bernard J. Walsh		22b. DATE SIGNED 2/3/67	
22c. PHYSICIAN'S NAME (Type) BERNARD J. WALSH		22d. ADDRESS 1800 Eye Street, N. W. Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-6-67	23c. NAME OF CEMETERY OR CREMATORY Moreland Baptist Cem.	23d. LOCATION (City or Town) (County) (State) Albemarle County, Va.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02351

CERTIFICATE OF DEATH

02347

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 day 10 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3 NAME OF DECEASED (Type or print) <u>Maggie</u> First <u>Page</u> Middle <u>Fields</u> Last		4 DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/31/05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Darling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records, Olney, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: <u>Renal Stenosis & Urinemia</u> <u>Compensatory Heart Failure</u> <u>Hypertensive C.V. Disease</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/21/67</u> , to <u>2/22/67</u> that (I) (we) last saw the deceased alive on <u>2/22/67</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>2/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Ligon</u>		22d. ADDRESS <u>Smiley, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hsh Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>SANDY Spring Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>Rockville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>FEB 28 1967</u>	

02352

CERTIFICATE OF DEATH

02348

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington GARDENS</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Charles F FINK</u>				4. DATE OF DEATH <u>Feb. 17 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 4, 1884</u>	
9. AGE (In years last birthday) <u>82</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Michael FINK</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cullers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-18-1375</u>		17. INFORMANT <u>Thelma D. Jones - Daughter</u> Address <u>Lawson Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 332X DUE TO <u>HYPOSTATIC PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERY THROMBOSIS</u> (c) <u>3 DAYS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMPHYSEMA; ARTERIOSCLEROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 11</u> , 19 <u>67</u> , to <u>FEB. 17</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>FEB. 17</u> , 19 <u>67</u> , and that death occurred at <u>9 P.</u> M., from causes and on the date stated above							
22a. SIGNATURE <u>Joseph L. Moor</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>FEB. 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Redland Montgomery MD.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 Rockville</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

02353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02349

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		d. STREET ADDRESS <u>1802 Keokee St</u>	
3 NAME OF DECEASED (Type or print) <u>Gary</u> First <u>Paul</u> Middle <u>Finney</u> Last		4 DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6 CO. OR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>26 JUNE 1944</u>
9 AGE (in years lost birthday) yrs <u>20</u>		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13 FATHER'S NAME <u>Paul FINNEY</u>		14 MOTHER'S MAIDEN NAME <u>GERALINE STANLEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17 INFORMANT <u>PAUL FINNEY JR.</u>		Address <u>2141 CUNNINGHAM DR HAMPTON, VA.</u>	
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation due to carbon monoxide</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intoxication and smoke inhalation</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased burned in house fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:45</u> <u>2-7</u> <u>1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> While at home <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hyattsville PrGeo Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		22. DATE SIGNED <u>Feb. 7, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>W. W. Chambers Co. Riverdale, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10 FEB 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers Co. Riverdale, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02354 CERTIFICATE OF DEATH 02350

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville R.F.D.</u>				c. LENGTH OF STAY in 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>Parkville R.F.D.</u>			
3. NAME OF DECEASED (Type or print) <u>Carl Jacob Thomas Fisher</u>				4. DATE OF DEATH <u>Feb. 17 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/1902</u>	9. AGE (in years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Own farm</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jacob S. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Lelia Marvington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-14-4341</u>			
17. INFORMANT <u>Mrs. Ruth S. Fisher Parkville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/21, 1963</u> to <u>3/17, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/14, 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James P. Kerr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/1</u>	
22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr, M.D.</u>				22d. ADDRESS <u>Damascus, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City, town or county) (State) <u>Beallsville Md.</u>	
24. FUNERAL DIRECTOR <u>Constance C. Hilton Parkville Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 23 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02355

02351

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Lexington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY in lb 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 13 Tanner Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Deborah Middle Kay Last FROELICH		4. DATE OF DEATH Month February Day 13 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1965
9. AGE (In years lost birthday) 1 yrs		10. FUNDING YEAR Months 1 Days 1 Hours 1 Min. 1	11. BIRTHPLACE (County & State or foreign country) Patuxent River, Md.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jack Froelich		14. MOTHER'S MAIDEN NAME Shirley Cartledge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO N/A	17. INFORMANT Jack Froelich, 13 Tanner Ave. Lexington Park, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart disease 771X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial pneumonia DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Colitis, Meningomyelocele			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from Feb. 12 , 19 67 , to Feb. 13 , 19 67 that (I) (we) lost saw the deceased alive on Feb. 13 , 19 67 , and that death occurred at 1:00PM , from causes on and on the date stated above.			
22a. SIGNATURE A. E. Thompson		22b. DATE SIGNED Feb. 15, 1967	
22c. PHYSICIAN'S NAME (Type) A. E. Thompson, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-18-67	23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	23d. LOCATION (City or Town) (County) (State) Great Mills Maryland
24. FUNERAL DIRECTOR Robinson Funeral Home, Leonardtown, Md.		25a. REC'D BY REGISTRAR Feb 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
20 M 1/66

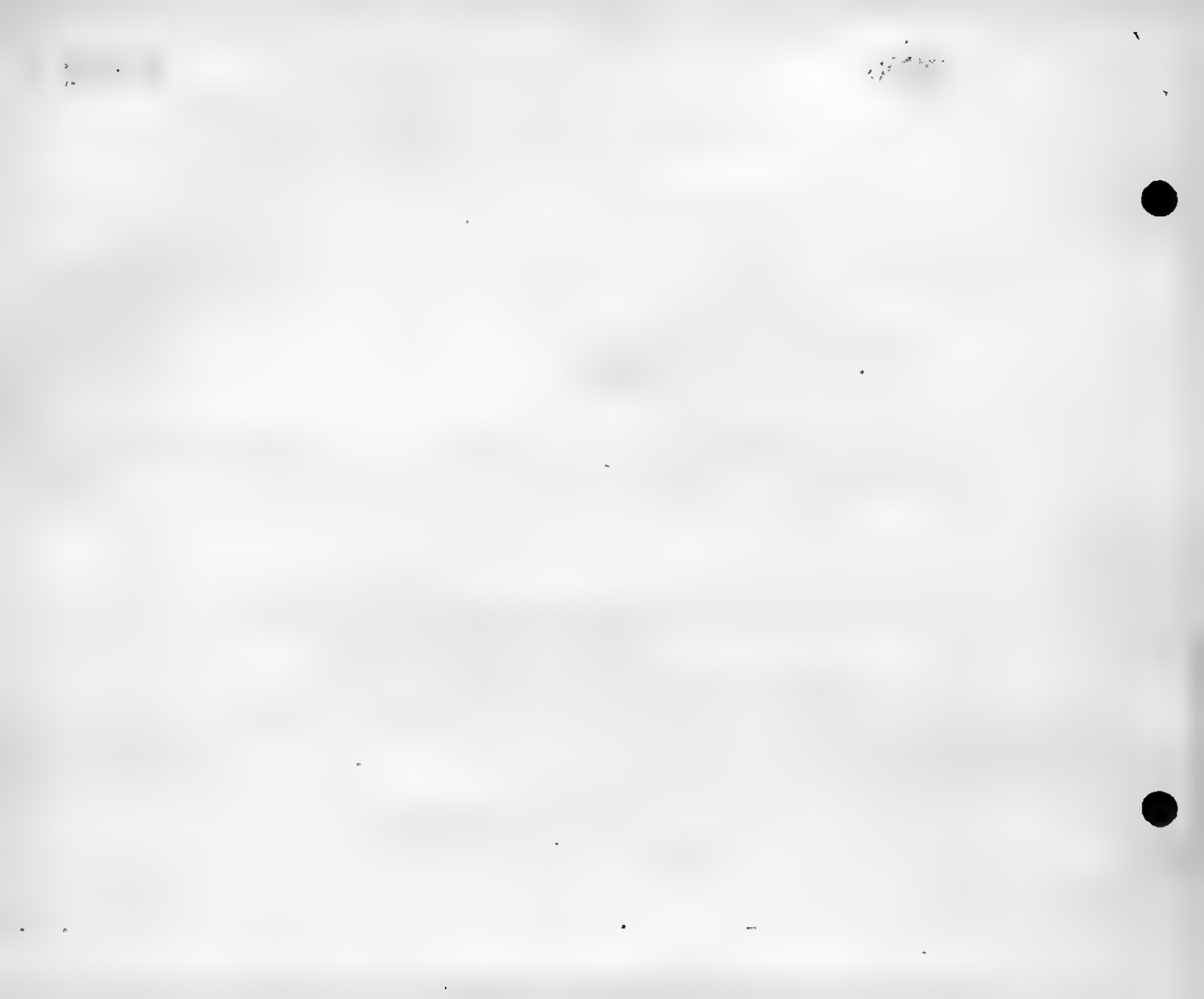
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02356

CERTIFICATE OF DEATH

02352

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor 5721 Grosvenor Ln.</u>	
d. STREET ADDRESS <u>7208 Carridge Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>B</u> Last <u>Fuller</u>		4 DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>m</u>	6 COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/9/1885</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice-Pres.-Connected</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>Goodrich Tire</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>288-16-5851</u>	
17 INFORMANT <u>Son</u>		4710 Edgemoor Lane Bethesda, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Astrocystoma, grade II</u> 1929 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) _____ (c) _____		INTERVA. BETWEEN ONSET AND DEATH <u>Sept 26, 1966</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from <u>1955</u> to <u>2/16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1-26-1967</u> , and that death occurred at <u>12:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Geo. A. Gray, Jr.</u>		22b. DATE SIGNED <u>2-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Geo. A. GRAY, JR MD.</u>		22d. ADDRESS <u>4710 Chevy Chase Drive, Chevy Chase, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-18-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Punphung</u>		25a. REC'D BY REGISTRAR <u>Bethesda, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>20 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.

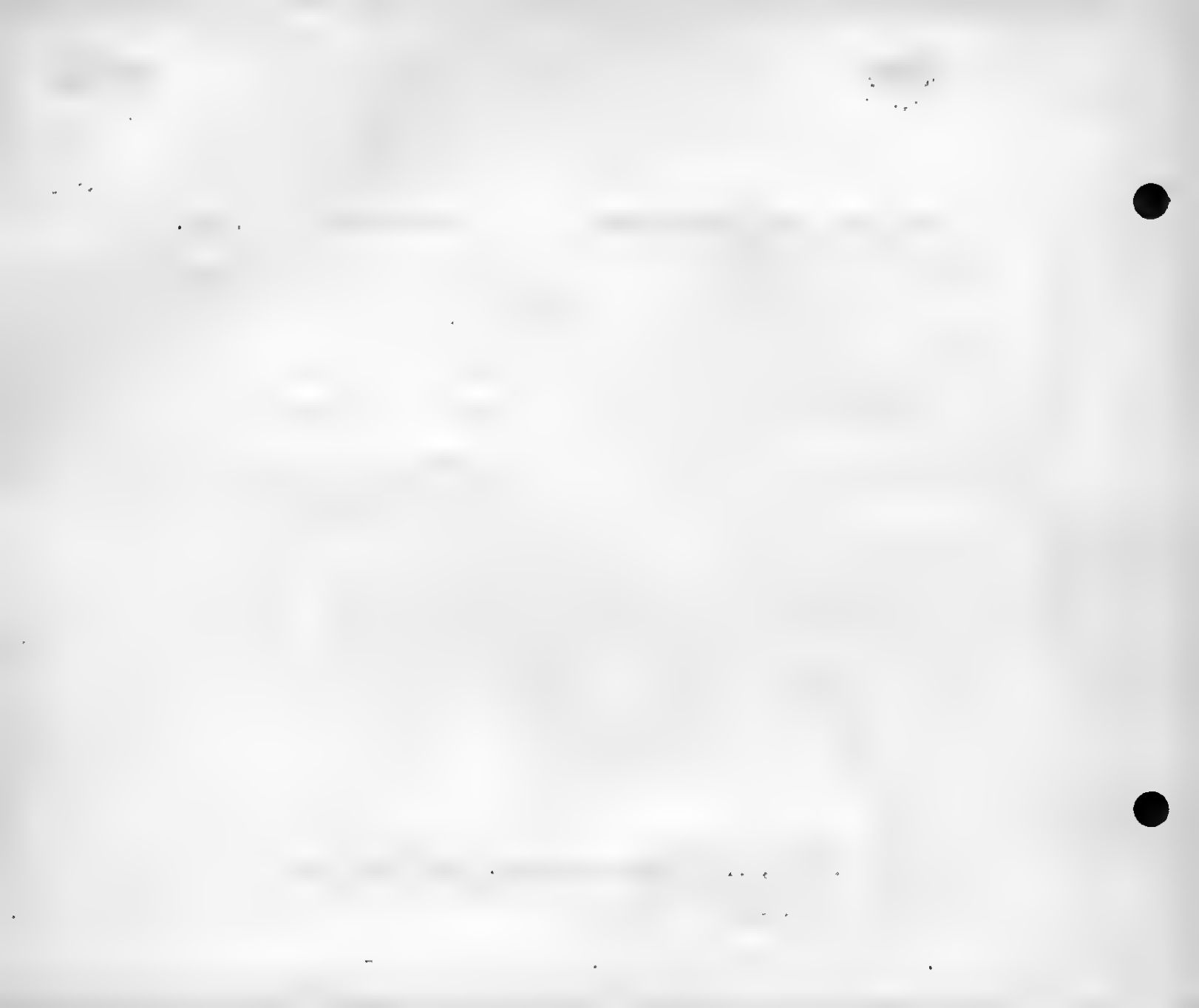
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #11 infor. taken from birth cert.

02357

CERTIFICATE OF DEATH

02353

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutor: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b few hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 2302 Brightseat Rd. Apt. 4	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH February 7 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Allen Russell Fullmer		14. MOTHER'S MAIDEN NAME Betty Matilda Holler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Father		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: only IMMEDIATE CAUSE (a) Premature infant approx 2 6wks gest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19____, to 19____, that (I) (we) last saw the deceased alive on 19____, and that death occurred at ____ M, from causes and on the date stated above.			
22a. SIGNATURE Carl Douglas Lord		22b. DATE SIGNED 2-6-67	
22c. PHYSICIAN'S NAME (Type) C. Lord, M.D. 7600 Carroll Ave.		22d. ADDRESS Takoma Park, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF 2-8-67	23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital	23d. LOCATION (City or Town) (County) (State) Takoma Park, Montgomery, Md.
24. FUNERAL DIRECTOR J. Roughcorn 7600 Carroll Ave., Takoma Park		25a. REC'D BY REGISTRAR DATE 2-8-67	25b. REGISTRAR'S SIGNATURE FEB 9 1967



02358

CERTIFICATE OF DEATH

02354

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY ----	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 37 Days	d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bridgeton
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 453 Coral Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Leslie Garrison		4. DATE OF DEATH Month Day Year February 12 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 May 1952
9. AGE (in years last birthday) 14 yrs		IF UNDER 1 YEAR Months Days 14	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leslie Wayne Garrison		14. MOTHER'S MAIDEN NAME Mary Emma McHenry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute Myelogenous Leukemia DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 9 days 16 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from 6 January 19 67 , to 12 February 19 67 , that (H) (we) last saw the deceased alive on 12 February 19 67 , and that death occurred at 2:10 M. from causes and on the date stated above.			
22a. SIGNATURE Leonard H. Brubaker, MD.		22b. DATE SIGNED 12 February 1967	
22c. PHYSICIAN'S NAME (Type) Leonard H. Brubaker, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-14-67	23c. NAME OF CEMETERY OR CREMATORY Overlook Cemetery	23d. LOCATION (City or Town) (County) (State) Bridgeton, New Jersey
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02359

CERTIFICATE OF DEATH

02355

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 4625 Hunt Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last FREDERICK A. GENAU		4 DATE OF DEATH Month Day Year 25 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 21, 1900
9 AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Officer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Aloysius T. Genau		14. MOTHER'S MAIDEN NAME Margaret Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-12-7692	
17. INFORMANT Wife		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Large heart failure DUE TO (b) Coronary arteriosclerotic heart disease DUE TO (c) 1958		INTERVAL BETWEEN ONSET AND DEATH 3 sec 2	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19 to 2/19/67 , 19, that (I) (we) last saw the deceased alive on 2/19/67 , 19, and that death occurred 2:55 P.M. from causes and on the date stated above.			
22a. SIGNATURE Bernard J. Walsh		22b. DATE SIGNED 2/19/67	
22c. PHYSICIAN'S NAME (Type) BERNARD J. WALSH		22d. ADDRESS 1800 Eye St. N.W. - DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-22-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

Cleared by Dr. Belden Reap, Coroner

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G556 3/13/67

02360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03808

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6704 Rannick Road		d. STREET ADDRESS 6704 Rannick Road	
3 NAME OF DECEASED (Type or print) Kathleen Sexton GILLIS		4 DATE OF DEATH Pronounced February 25, 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1912 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Kent Spiller		14 MOTHER'S MAIDEN NAME Kathleen Sexton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 5811 IMMEDIATE CAUSE (a) Laennec's Cirrhosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED February 26, 1967			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-8-1967	23c. NAME OF CEMETERY OR CREMATORY Hazelhurst Cemetery	23d. LOCATION (City or Town) (County) (State) Hazelhurst, Mississippi
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REG. STR. MAR 9 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Springate</i>	



02362

CERTIFICATE OF DEATH

Reg. Dist. No. 02357

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12905 Eloise Ave</u>				d. STREET ADDRESS <u>12905 Eloise Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF (Type or print) <u>Romana</u>		First Middle Last <u>Gonano</u>		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1 1875</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francesco Riccobon</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Cigliotta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>235-05-7387 F2</u>		INFORMANT Address <u>Mrs Belle Gonano 12905 Eloise Ave Rockville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 14</u> , 19 <u>66</u> , to <u>2-27</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>67</u> , and that death occurred at <u>7:45 M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Corinne Cooper</u>		M.D. <u>104 S Washington St</u>		DATE SIGNED <u>2-28-67</u>			
PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		<u>Rockville, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkview</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home Rockville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

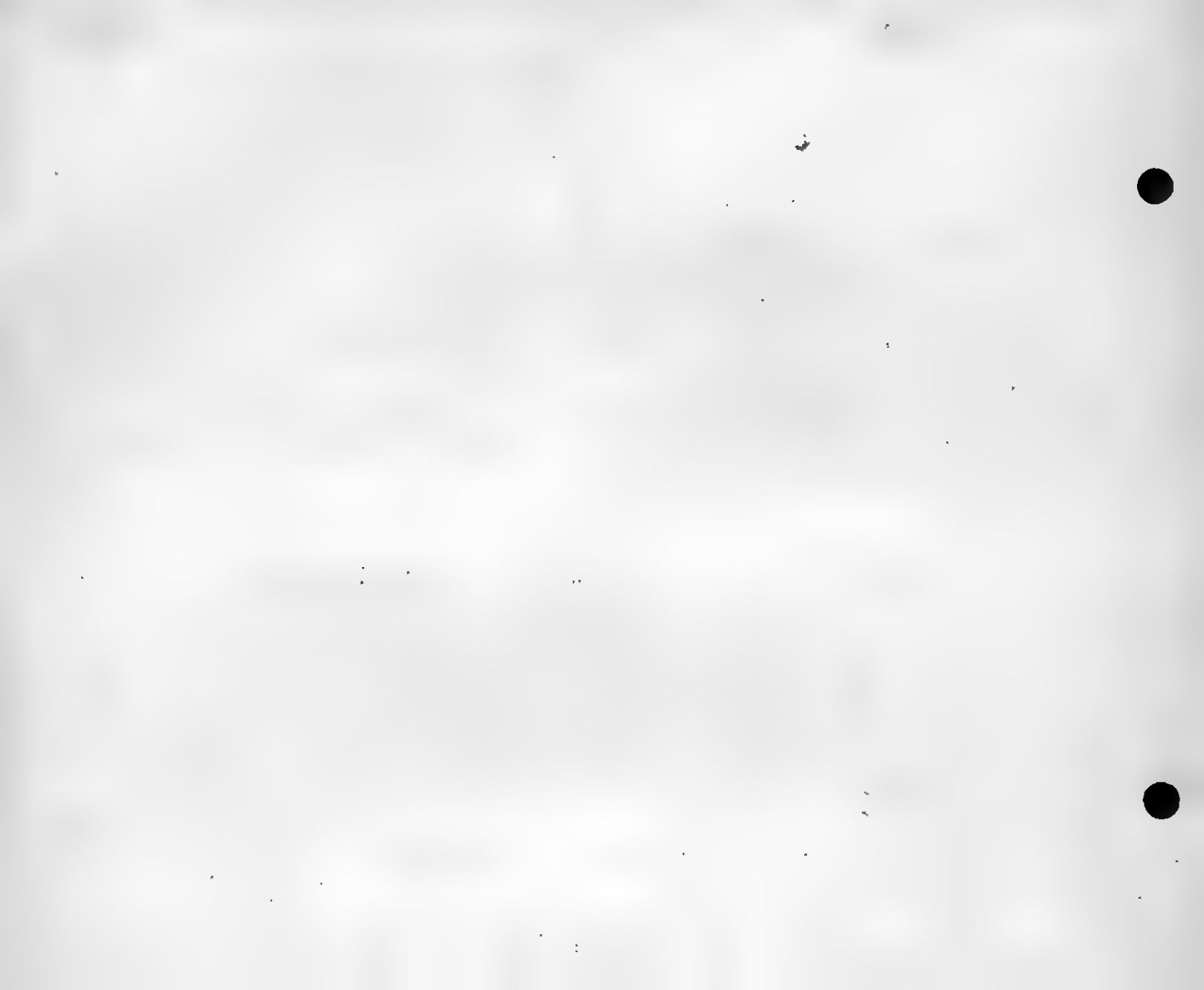


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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 MARYLAND											
02363 CERTIFICATE OF DEATH 02358											
Item 4 - 1111 0586 2/20/67 mh											
1. PLACE OF DEATH a. CDUNITY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE California b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fair Oaks					
c. LENGTH OF STAY IN ID 68 days						d. STREET ADDRESS 6752 Will Rogers Drive					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland											
3. NAME OF DECEASED (Type or print) First Middle Last Wilda Mae Grace						4. DATE OF DEATH Month Day Year Feb. 15, 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1929		9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Mississippi			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Murl Scribner						14. MOTHER'S MAIDEN NAME Eva Coggin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 416-36-9361		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic & Renal failure DUE TO (c) Metastatic Adrenal carcinoma (widespread)										INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from Dec. 9, 1966, to Feb. 15, 1967, that (we) last saw the deceased alive on Feb. 15, 1967, and that death occurred at 7:02 M. from the causes and on the date stated above.											
22a. SIGNATURE David F. Paulson						PM MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. ATTENDING PHYS. <input type="checkbox"/>			22b. DATE SIGNED 16 Feb. 1967		
22c. PHYSICIAN'S NAME (Type) David F. Paulson, MD.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) 2-17-67				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State) Mobile, Ala.		
24. FUNERAL DIRECTOR Fitzsim 389 R.I. Ave NW Wash. DC.						ADDRESS		25a. REC'D BY REGISTRAR FEB 21 1967		25b. REGISTRAR'S SIGNATURE Charles J. Judge	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

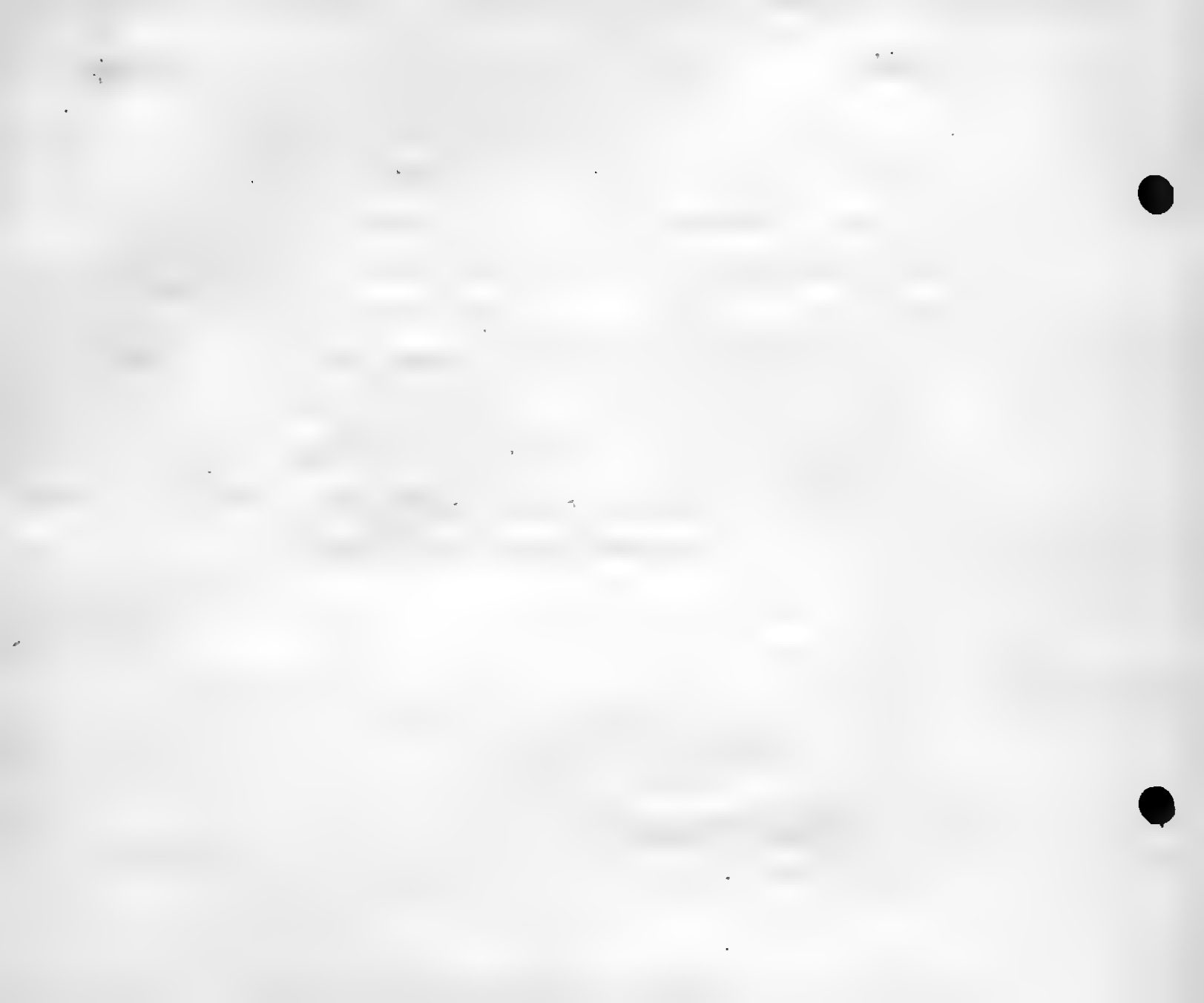
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02359

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 East Diamond Ave</u>				d. STREET ADDRESS <u>6 East Diamond Ave</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence German Griffith</u>				4. DATE OF DEATH Month Day Year <u>Feb - 28 1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/31/1899</u>	9 AGE (In years last birthday) <u>67</u> yrs	10 IF UNDER 1 YEAR Months Days Hours Min.		11 IF UNDER 24 HRS Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Clarence M. Griffith</u>				14 MOTHER'S MAIDEN NAME <u>Grace Johnson</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>216-22-8341</u>		17 INFORMANT <u>Mr. Walter M. Royal, Rockville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Disease</u> DUE TO (c) <u>11201</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>2/28/67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>3/3/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d LOCATION (City or town) (County) (State) <u>Gaithersburg Md.</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>				25a REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02365

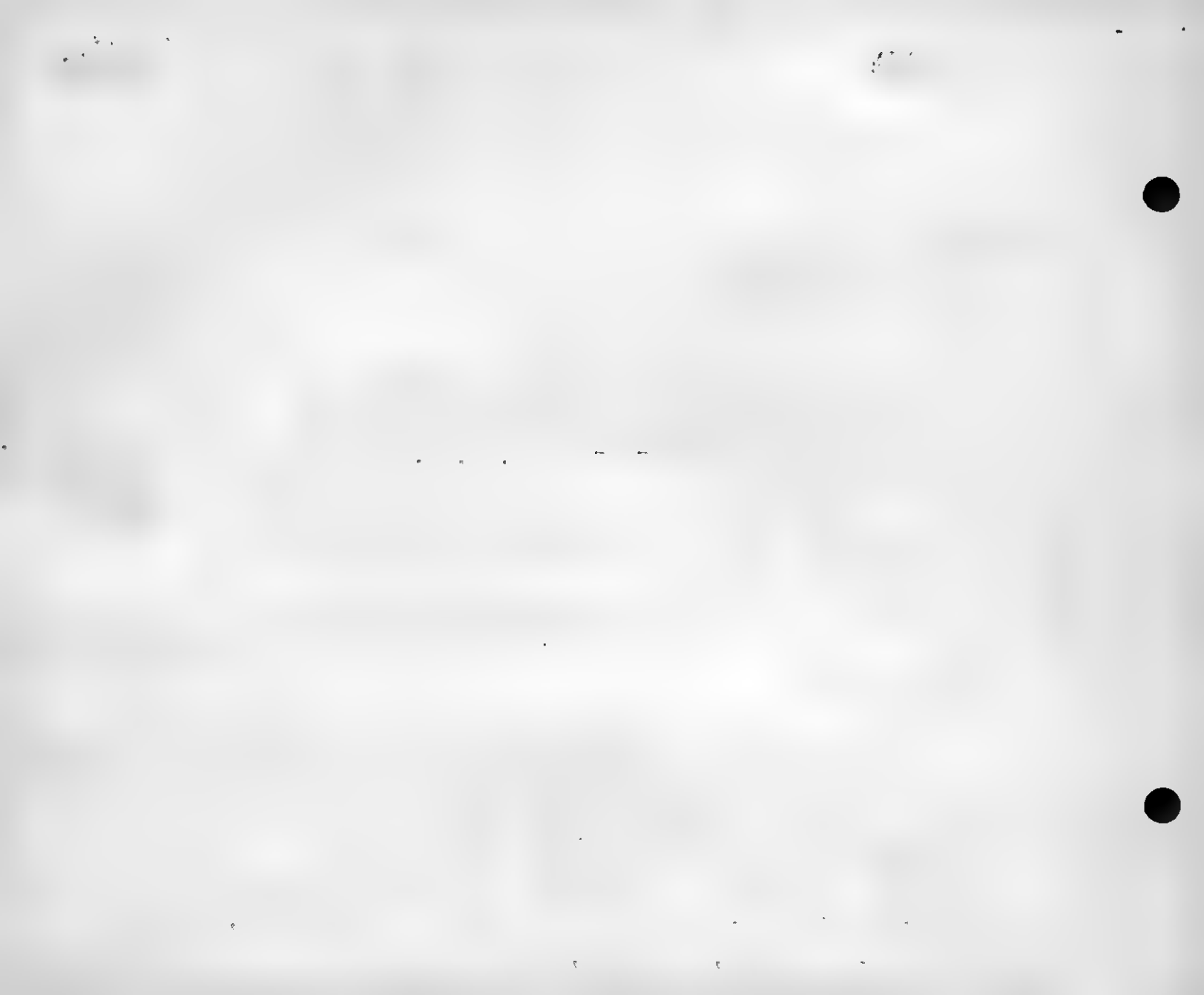
CERTIFICATE OF DEATH

02360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>10112 Parkwood Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Marie</u> Last <u>GRINER</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Naham Boyle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Estelle Drury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>321-20-2741</u>	
17. INFORMANT <u>son-in-law</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsicemia (Paracolon Bacillus)</u> DUE TO (b) <u>Pyelonephritis, Acute & Chronic</u> DUE TO (c) <u>24RS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24RS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATOID ARTHRITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9/67</u> , 19, to <u>2/1/67</u> , 19, that (I) (we) last saw the deceased alive on <u>2/1/67</u> , 19, and that death occurred at <u>2:57 P.M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>Henry C. Scruggs</u> M.D.		22b. DATE SIGNED <u>2/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS</u>		22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 2-2-67</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Fairlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Decatur, Illinois</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Grunevald, Mrs. Susan

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02366					02361					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Montgomery</i>		MARYLAND			a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>20 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			d. STREET ADDRESS <i>212 St. Lawrence Drive</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>212 St. Lawrence Drive</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First <i>Maud</i>		Middle <i>Susan</i>		Last <i>Grunevald</i>		Month <i>February</i>		Day <i>28</i>		
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 15, 1880</i>		9. AGE (In years last birthday) <i>86</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>George C. Carpenter</i>					14. MOTHER'S MAIDEN NAME <i>Mary Casey</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>213-56-0517</i>		17. INFORMANT <i>Mrs. Gladys Gillins</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					Address <i>212 St. Lawrence Drive Silver Spring, Md.</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary thrombosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Generalized and coronary arteriosclerosis</i>					Severely aortic					
DUE TO (c) <i>Cerebral thrombosis</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral thrombosis</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1962</i> , 19 <i>February 28</i> , 1967, that (I) (we) last saw the deceased alive on <i>February 23</i> , 1967, and that death occurred at <i>8:30</i> AM, from the causes and on the date stated above.										
22a. SIGNATURE <i>Bennet A. Porter, Jr. M.D.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>February 28, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Bennet A. Porter, Jr. M.D.</i>					22d. ADDRESS <i>9301 Colesville Rd., Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 3, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Prince Georges Co. Md.</i>			
24. FUNERAL DIRECTOR <i>Glen Carter Warner E. Humphrey, Inc.</i>					ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>MAR 3 1967</i>										

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02367

CERTIFICATE OF DEATH

02362

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1505 Gleason Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. James Isaac Gruver</u>		4. DATE OF DEATH Month Day Year <u>February 12 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-86</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Isaac Gruver</u>		14. MOTHER'S MAIDEN NAME <u>Martha J. Sharp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>215-50-1330</u>	
17. INFORMANT <u>Mrs. Nora Terrill</u> <u>1505 Gleason Street</u> <u>Silver Spring, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 23, 1967</u> to <u>Feb 12, 1967</u> that (I) (we) last saw the deceased alive on <u>Feb. 11, 1967</u> , and that death occurred at <u>1:00 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Bernard A Fitzgerald</u>		22b. DATE SIGNED <u>2-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>		22d. ADDRESS <u>217 UNIV. BLVD SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>Feb 17, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Scotts Valley Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Paola, Kansas</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Feb 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Yago</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02368

02363

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN MD MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1122 E st. S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle E Last Haas		4. DATE OF DEATH Month Feb. Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-1872 9. AGE (In years last birthday) 94 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail clerk-retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Bladen		14. MOTHER'S MAIDEN NAME Elizabeth Babbie Katrie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Bladen		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Arteriosclerosis DUE TO (c) Accelerated cardiac disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2.5 days underlying cause last many years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 17 67 to Feb 2, 1967 , that (I) (we) last saw the deceased alive on Feb 2 1967 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Harry G. Dudley		22b. DATE SIGNED Feb 2 67	
22c. PHYSICIAN'S NAME (Type) Harry G. Dudley		22d. ADDRESS 4601 Nichols Ave SE Wash, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bury		23b. DATE THEREOF 2/6/67	
23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR FEB 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

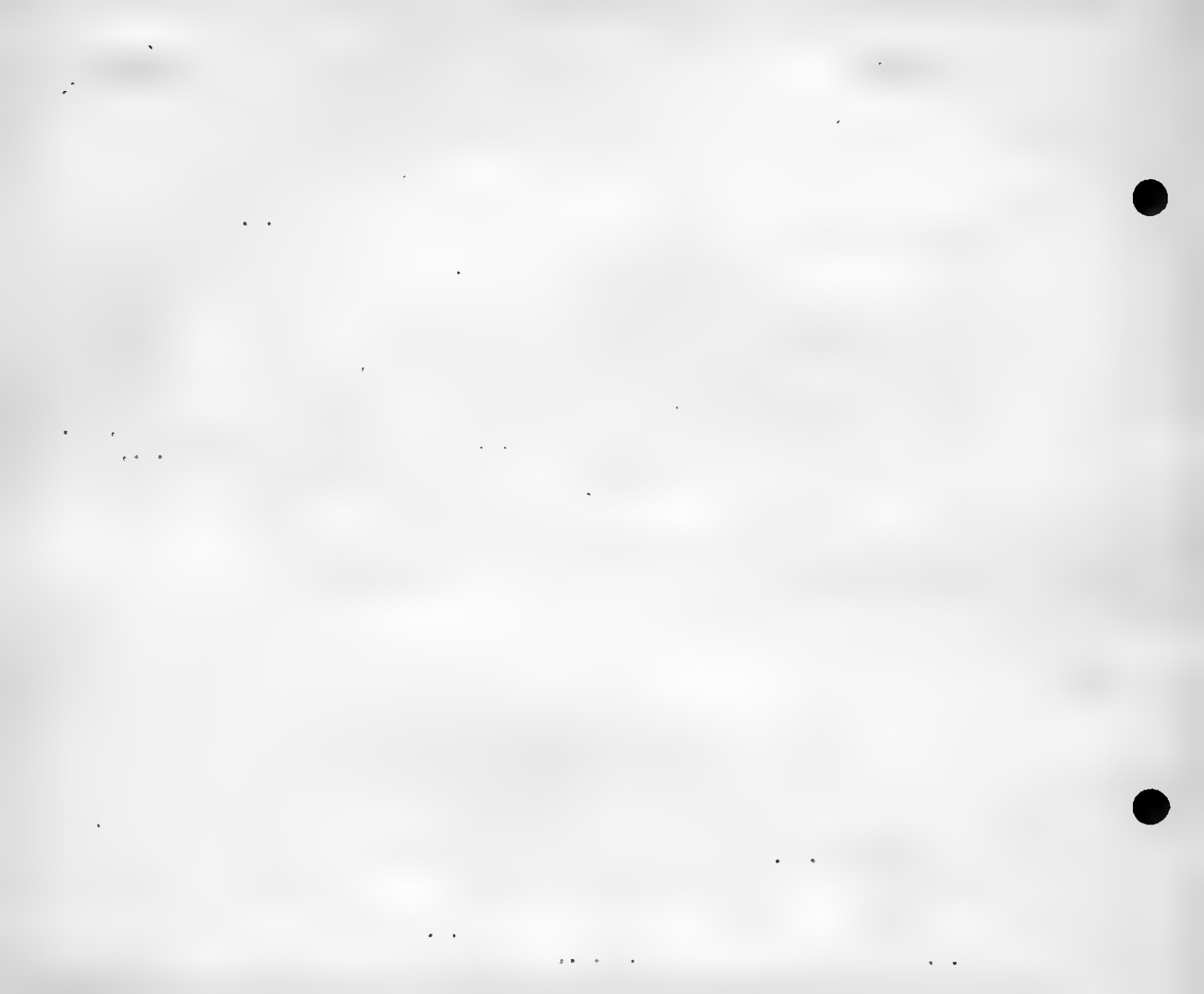
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02369

CERTIFICATE OF DEATH

02364

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN it <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlanta</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS <u>3842 The Ascent N.E.</u>			
3 NAME OF DECEASED (Type or print) <u>William Loring HALL Jr.</u>				4 DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>19 67</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10 August 1948</u>	9 AGE (in years lost birthday) <u>18</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Long Beach, California</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Loring HALL</u>				14. MOTHER'S MAIDEN NAME <u>Vivian McCREADY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>254 78 0141</u>		17. INFORMANT <u>Vivian HALL, 3842 The Ascent N.E.,</u> Address <u>Atlanta, Ga.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7542 Congenital Heart Disease</u> DUE TO (b) <u>Atrial septal defect</u> DUE TO (c) <u>Anomolous pulmonary venous drainage</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>8 February, 19 67</u> , to <u>24 February 67</u> that <u>10</u> (we) last saw the deceased alive on <u>24 February 19 67</u> , and that death occurred at <u>5:30AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>W. R. Hix</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>24 Feb. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. R. HIX, LCDR MC USN</u>				22d. ADDRESS <u>Naval Hospital, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sandersville City</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandersville, Georgia</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, 1400 Chapin St., N.W., Washington,</u>				25a. REC'D BY REGISTRAR <u>Feb 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



02370

CERTIFICATE OF DEATH

02365

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>3807 WENDY LANE</u>	
3 NAME OF DECEASED (Type or print) <u>RICHARD G. HANES</u>		4 DATE OF DEATH Month <u>2</u> - Day <u>16</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/20</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TECH. - DEPT. ARMY</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	9. AGE (In years last birthday) <u>46</u> yrs
10a. BIRTHPLACE (County & State or foreign country) <u>N. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse J. Hanes</u>		14. MOTHER'S MAIDEN NAME <u>Anna Ketner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>238-30-8609</u>	
17. INFORMANT <u>Louise E. Hanes</u>		Address <u>3807 Wendy Lane Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>5400</u> IMMEDIATE CAUSE (a) <u>Hemorrhagic shock due to</u> DUE TO (b) <u>Gastrointestinal hemorrhage due to</u> DUE TO (c) <u>Multiple Gastric Ulcers</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>2/16, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/16, 1967</u> , and that death occurred at <u>3 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>2/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>		22d. ADDRESS <u>8641 Colesville Rd., S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Glenn Carter</u> ADDRESS <u>8434 Georgia Ave.</u>	
25b. REGISTRAR'S SIGNATURE <u>Glenn Carter</u>		DATE <u>FEB 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02371

CERTIFICATE OF DEATH

02366

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 13807 Notley Road			
3. NAME OF DECEASED (Type or print) First Middle Last ROSELLA L. HARVEY						4. DATE OF DEATH Month Day Year Feb. 11 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/10/81		9. AGE (In years last birthday) yrs 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Gorman, West Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Nine						14. MOTHER'S MAIDEN NAME Sophia Nine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Sil., Sp., Md. Mrs. Ruby Miller - 13807 Notley Road,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) ACUTE CORONARY Insufficiency DUE TO (b) ARTERIOSCLEROTIC Heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 5:45 AM , from causes and on the date stated above.									
22a. SIGNATURE Morris Perry						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/11/67	
22c. PHYSICIAN'S NAME (Type) Morris Perry						22d. ADDRESS 17602 Georgia Avenue Silver Springs Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland Maryland			
24. FUNERAL DIRECTOR (Name) Pearson's Funeral Home						25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Cleared with Medical Examiner - md

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02372						02367					
1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>902 Langley Drive</u>						d. STREET ADDRESS <u>902 Langley Drive</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ralph William Heigham</u>						4. DATE OF DEATH Month Day Year <u>February 12 1967</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>1 2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garment</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Long Island, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William H. Heigham</u>						14. MOTHER'S MAIDEN NAME <u>Ella Ittner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>						16. SOCIAL SECURITY NO. <u>Yes</u>					
17. INFORMANT <u>Miss Una Heigham</u>						Address <u>902 Langley Drive Silver Spring, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Deкомпensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO (c) <u>?</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1-2 mo.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>12 Feb 1967</u> , that (I) (we) last saw the deceased alive on <u>11 Feb 1967</u> and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William And</u>						22b. DATE SIGNED <u>2/12/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>William And</u>						22d. ADDRESS <u>9006 Colesville Road, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>		23d. LOCATION (City, town or county) <u>Oxen Hill, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Easter</u> <u>Warner E. Humphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

02373

CERTIFICATE OF DEATH

03332

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	7 LENGTH OF STAY IN 1b <u>5 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>7503 Valest</u>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>Hendrickson</u> Middle <u>N</u> Last		4. DATE OF DEATH <u>2-28</u> Month <u>2</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-90</u> Year <u>76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County, State, or foreign country) <u>New York</u>
13. FATHER'S NAME <u>Cleveland Cadoo, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>147-03-2741D</u>	17. INFORMANT <u>Betty H. Fiske - daughter - same</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia, hypostatic, bilateral</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary arteriosclerosis with myocardial fibrosis, patchy with heart block (EKG)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>67</u> , to <u>2/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>67</u> , and that death occurred at <u>2:50 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Frank G. Jagers Jr.</u> M.D.		22b. DATE SIGNED <u>2/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK G. JAGGERS JR</u>		22d. ADDRESS <u>5702 WISCONSIN AVE</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF <u>2-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>The Old Tennent Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Tennent, New Jersey</u>
24. FUNERAL DIRECTOR <u>Robert C. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02374

CERTIFICATE OF DEATH

02368

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>4 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>				d. STREET ADDRESS <u>1119 North Belgrad Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clyde Leroy Hesson</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-18-1888</u>		9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired bank worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL Co., MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DANIEL J. HESSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. GARNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO <u>219-0392-50</u>		17. INFORMANT <u>CHARLES HESSON</u> Address <u>1119 N. BELGRAD RD. SILVER SPRING, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <u>4500</u> IMMEDIATE CAUSE (a) _____ DUE TO (b) <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Nephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>9 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>31 Jan 1967</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>William D. And</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2 Feb 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.D. And</u>				22d. ADDRESS <u>TANNEYTOWN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>TANNEYTOWN, CARROLL, MD.</u>	
24. FUNERAL DIRECTOR <u>G.E. Fussy Son</u>				ADDRESS <u>TANNEYTOWN, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02375

CERTIFICATE OF DEATH

02369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Washington</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY IN 1b <u>11 months</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Epidemic Nursing Home</u>				d STREET ADDRESS <u>1707- Columbia Rd. N.W.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>B</u> Last <u>Hogsett</u>				4 DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 22, 1882</u>	9 AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Lexington-Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>JAMES W. BARE</u>				14 MOTHER'S MAIDEN NAME <u>Mary E Ayres</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 351X DUE TO (b) <u>A.S. cerebro vasc. dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>66</u> , to <u>2-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>D. L. Sengstack M.D.</u>				22b DATE SIGNED <u>2-16-67</u>		22c MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22e PHYSICIAN'S NAME (Type)				22d ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>2/20/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Stonewall Jackson</u>		23d LOCATION (City or Town) (County) (State) <u>Lexington Va</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				25a REC'D BY REGISTRAR <u>Washington, D. C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

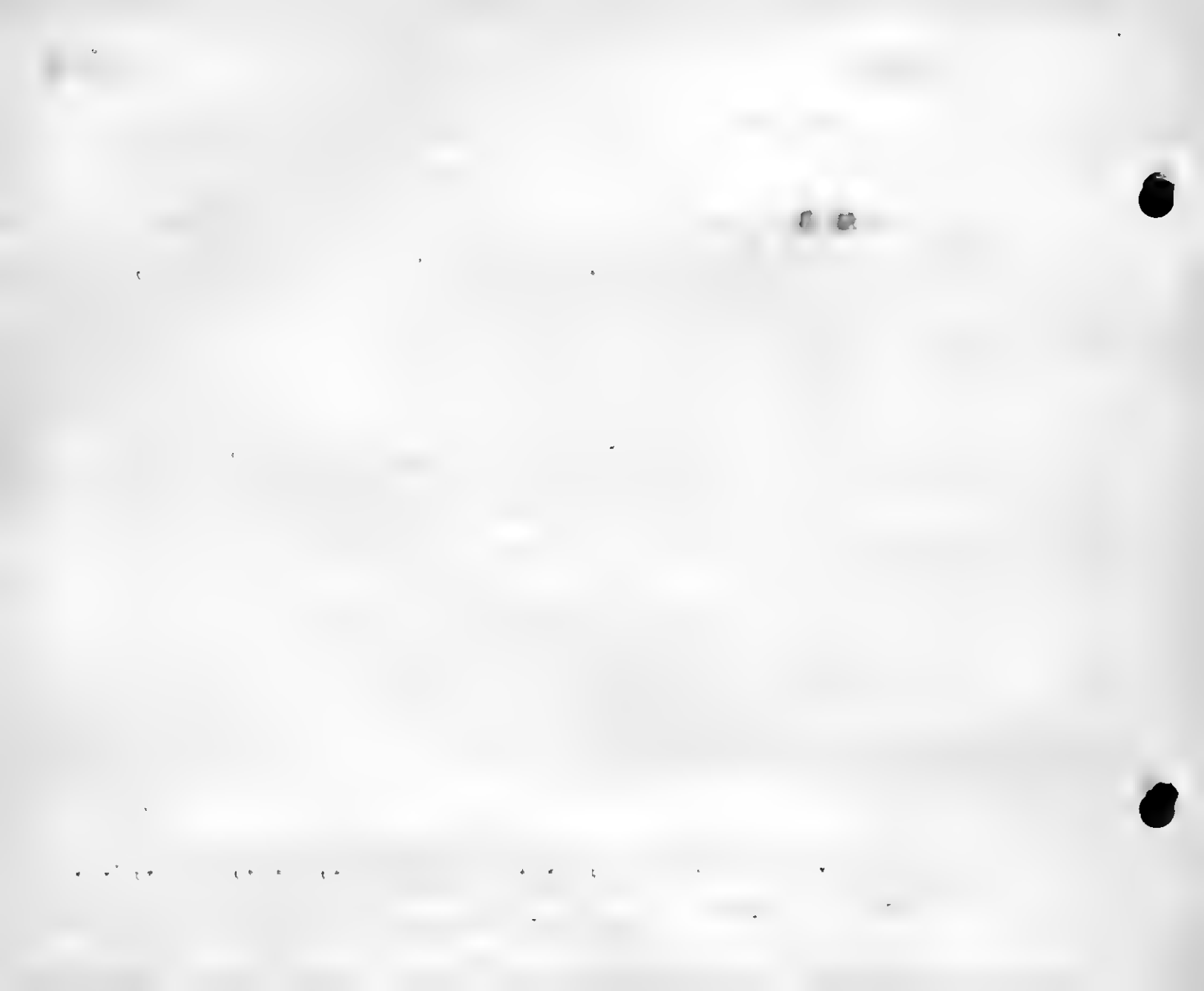
02376

CERTIFICATE OF DEATH

02370

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA		c LENGTH OF STAY IN IS KENSINGTON	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL		d. STREET ADDRESS 10208 GREENFIELD STREET	
3. NAME OF DECEASED (Type or print) First Middle Last ALAN M. HOLMES		4 DATE OF DEATH Month Day Year FEBRUARY 7, 1967	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1903
9 AGE (in years last birthday) 63 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Worker		10b. KIND OF BUSINESS OR INDUSTRY H. I. J.	
11. BIRTHPLACE (County & State, or foreign country) Centerville, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Holmes		14. MOTHER'S MAIDEN NAME Erine Reid	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI		16 SOCIAL SECURITY NO 579-12-3524	
17. INFORMANT JANET R. HOLMES		Address yes	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4/201 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction (c) Coronary Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the decedent from 5/12 , 19 46 to 2/7 , 19 67 ; that (I) (we) last saw the decedent alive on 4/29 , 19 67 , and that death occurred at 1:30 PM, from causes and on the date stated above.			
22a. SIGNATURE E. Stuart Lyddane		22b. DATE SIGNED 2/7/67	
22c. PHYSICIAN'S NAME (Type) E. STUART LYDDANE, M.D.		22d ADDRESS 3066 Q ST., N.W., WASH., D.C.	
23a BURIAL, CREMATION, REMOVAL (Specify) 2/8/1967		23b DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR JOSEPH GAULERS		25b REC'D BY REGISTRAR SON'S, INC.	
25a REGISTRAR'S SIGNATURE JOSEPH GAULERS		25b REGISTRAR'S SIGNATURE SON'S, INC.	
DATE FEB 14 1967		DATE FEB 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02377

CERTIFICATE OF DEATH

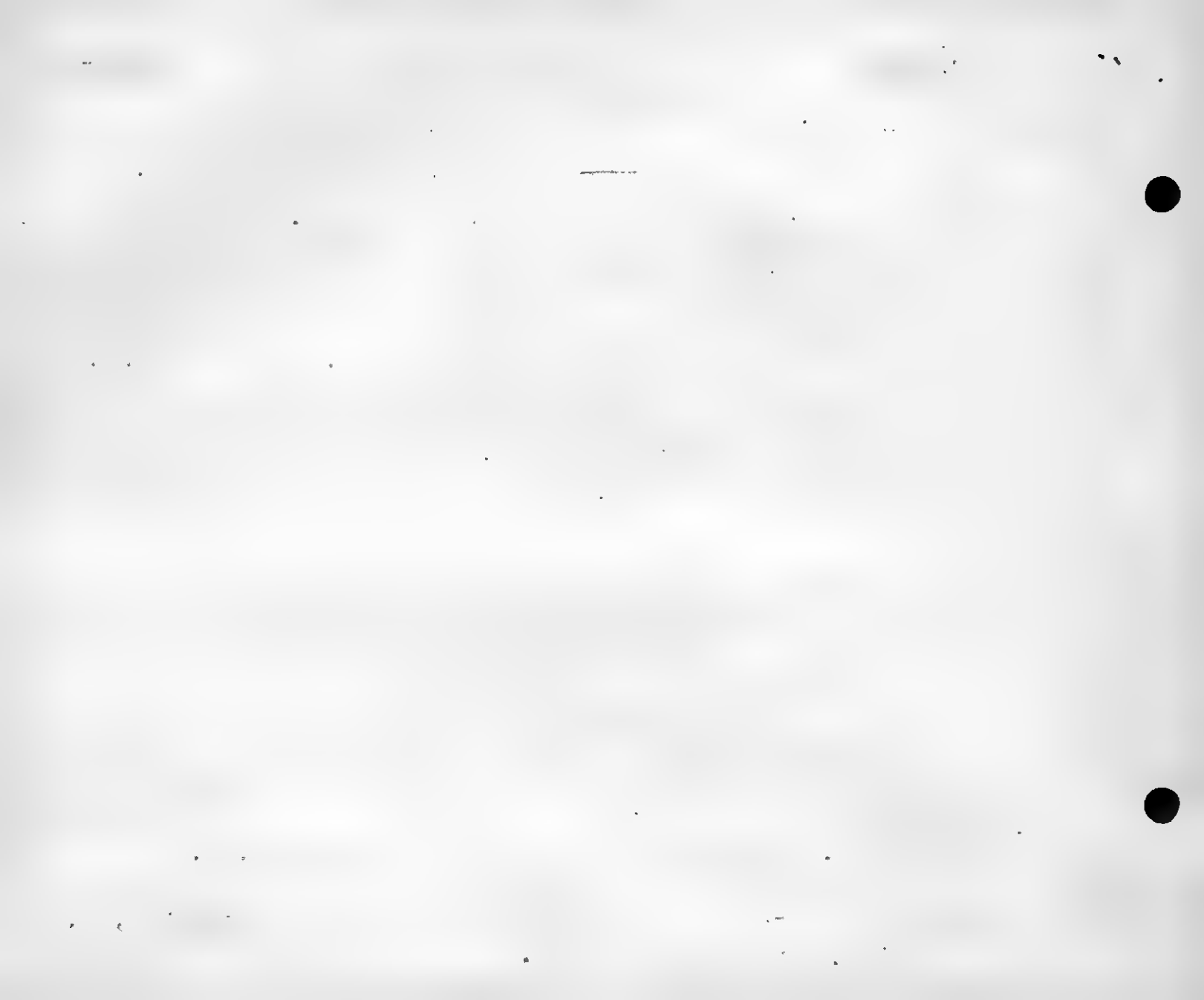
02371

1 PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring, Md. c. LENGTH OF STAY in 1b 50 yrs D.O.A.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1200 Hornell Dr.	
3 NAME OF DECEASED (Type or print) First CALVIN Middle Miller Last Howes		4 DATE OF DEATH Month 2 Day 15 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/25/06
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months 2 Days 15 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Manager		10b. KIND OF BUSINESS OR INDUSTRY Trash Disposal	
11 BIRTHPLACE (County & State or foreign country) Montgomery Co., Md.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Winfield Howes		14. MOTHER'S MAIDEN NAME Frances Emma Leishear	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578 10 6413	
17. INFORMANT Mrs. Margaret Howes		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: CHRONIC CONGESTIVE HEART FAILURE IMMEDIATE CAUSE (a) CHRONIC CONGESTIVE HEART FAILURE DUE TO (b) CORONARY ARTERY DISEASE DUE TO (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 HRS. 124 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , to 2-15 , 1967, that (I) (we) last saw the deceased alive on 2-11 , 1967, and that death occurred at 7:00 P.M. , from causes and on the date stated above.			
22a. SIGNATURE G. Leonard Gold		22b. DATE SIGNED 2-15/67	
22c. PHYSICIAN'S NAME (Type) G. Leonard Gold		22d. ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-67	
23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or Town) (County) (State) Laytonsville, Md.	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with Medical Examiner - GFF



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VR A15 (4)
20 M 1/66

02378

CERTIFICATE OF DEATH

02372

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>1 year</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH</u> <u>PENN</u> <u>HUNT</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY</u> <u>18</u> <u>19 67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LETTER CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	9. AGE in years (thdy) yrs <u>82</u>
11. BIRTHPLACE (County & State, or foreign country) <u>OXFORD NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>David Nicholson Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Addie Hester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Son <u>Joseph Hunt</u>		4705 Chestnut St. Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PSYCHIC BACTEREMIA OR SEPTICEMIA</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DECUBITUS ULCERS</u> DUE TO (c) <u>ASCVD, CHRONIC BRAIN SYNDROME.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 WEEKS +</u> <u>Few MONTHS.</u> <u>SEVERAL YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>February 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>February 18</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>HUGO G. GRAZIANI</u>		22b. DATE SIGNED <u>2/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>		22d. ADDRESS <u>10101 GEORGIA AVE, SILV. SP., MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Burial-transit 2-20-67 Elmwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Oxford, No. Carolina</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



02379

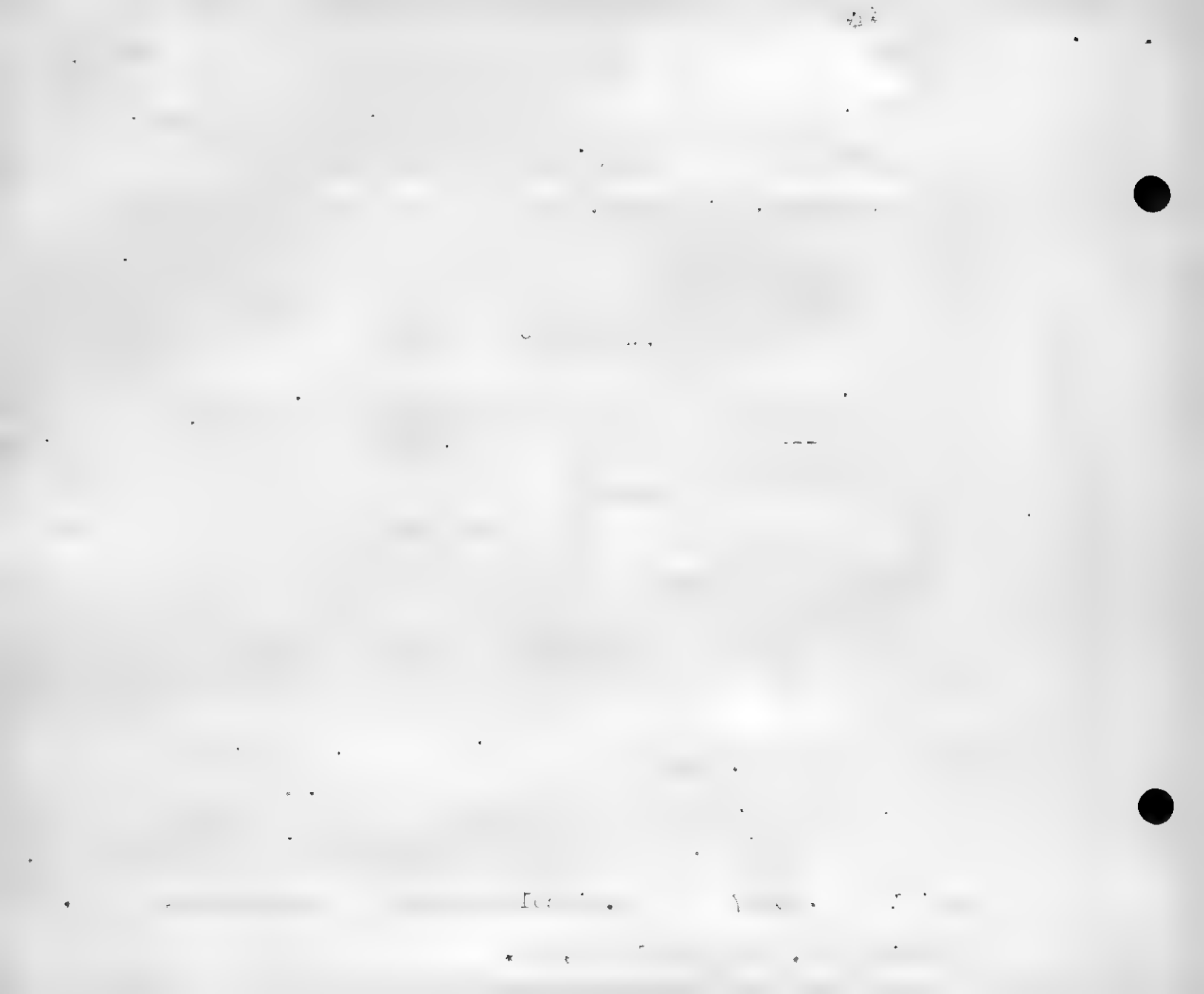
CERTIFICATE OF DEATH

02373

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 206 First Street, Greenwood Acres		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patricia Ann Ingle		4. DATE OF DEATH Month February Day 3 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1952	9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Schools		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry R. Ingle		14. MOTHER'S MAIDEN NAME Patricia H. Lusby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia (organism unknown) DUE TO (c) Acute Lymphocytic Leukemia					INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 Days 2 1/2 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that the (this hospital) attended the deceased from 20 January , 19 67 , to 3 February 19 67 , that I (we) last saw the deceased alive on 3 February 19 67 , and that death occurred at 2:05M , from the causes and on the date stated above.					
22a. SIGNATURE <i>Ronald A. Yankee</i>		22b. DATE SIGNED 2/3/67		22c. PHYSICIAN'S NAME (Type) Ronald A. Yankee	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City, town or county) Bladensburg, Md.					
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02380

CERTIFICATE OF DEATH

02374

1 PLACE OF DEATH a COUNTY <u>Montgomery Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md</u>		c LENGTH OF STAY IN 1b <u>6 mo.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d STREET ADDRESS <u>River Rd, Box 35</u>	
3 NAME OF DECEASED (Type or print) <u>Robert H. Jackson</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/7/1913</u>
9a AGE (In years lost birthday) <u>53</u> yrs.		9b IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont Co</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Mont. Co.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Benjamin Jackson</u>		14 MOTHER'S MAIDEN NAME <u>Clara Jackson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u> </u>	
17 INFORMANT <u>Mrs. Robert Jackson</u>		Address <u>T.H. #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Melanotic carcinoma</u> DUE TO <u> </u> (b) <u>Carcinoma of the prostate</u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> to <u>2-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-9</u> 19 <u>67</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Blacy</u>		22b DATE SIGNED <u>2-10-67</u>	
22c PHYSICIAN'S NAME (Type) <u>D.L. Blacy</u>		22d ADDRESS <u>809 Veirs Mill Rd Rockville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>2-10-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>Robert L. Howard</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b DATE <u>FEB 16 1967</u>		25c REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02381

CERTIFICATE OF DEATH

02375

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Virginia b. COUNTY Prince William ✓ MISSISSIPPI			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital				d. STREET ADDRESS 4014-A, Marine Corps Schools			
3. NAME OF DECEASED (Type or print) First John Middle Willis Last Jones				4. DATE OF DEATH Month Feb. Day 17 Year 19 67			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1928		9. AGE (in years last birthday) yrs. 38	10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Oliver Jones				14. MOTHER'S MAIDEN NAME Willie Pullen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Nov. 20, 1947		16. SOCIAL SECURITY NO. 425 32 6539		17. INFORMANT Dorothy G. Jones Address Qtrs. 4014-A Marine Corps Schools, Quantico, Va			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Irreversible Brain Edema 1700 DUE TO (b) Metastatic Malignant Melanoma To Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 6 Days Approx 6 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 19 67 , to Feb. 17, 19 67 , that (I) (we) lost saw the deceased alive on Feb. 17, 19 67 , and that death occurred at 2:02 A.M. from causes and on the date stated above.							
22a. SIGNATURE Francis E. Senn Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 17, 1967	
22c. PHYSICIAN'S NAME (Type) Francis E. Senn Jr.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-21-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR W W Chambers Co 1400 Chapin St N.W. Wash. D.C.				25a. REC'D BY REGISTRAR DATE FEB 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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25M 1/67

<div> <div> <div>02382</div> <div>Item #4 Film #G 311-167 pc</div> </div> <div> <div>03852</div> <div>Item #10 Film #G 311-167 pc</div> </div> </div> <div> <div> <div>1</div> <div> <div>02382</div> <div>Item #4 Film #G 311-167 pc</div> </div> </div> <div> <div>03852</div> <div>Item #10 Film #G 311-167 pc</div> </div> </div>										
<div>1 PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Montgomery</div> <div>MARYLAND</div>					<div>2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div>					
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Takoma Park</div>			<div>c. LENGTH OF STAY IN 1b</div> <div>6 days</div>		<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Morningside</div>					
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Washington Sanitarium and Hospital</div>					<div>d. STREET ADDRESS</div> <div>6324 Suitland Road</div>			<div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		
<div>3 NAME OF DECEASED (Type or print)</div> <div>First Middle Last</div> <div>John Aloysius Joyce</div>					<div>4 DATE OF DEATH</div> <div>28 Month 2-27, 1967 19</div>					
<div>5 SEX</div> <div>male</div>		<div>6 COLOR OR RACE</div> <div>White</div>		<div>7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8 DATE OF BIRTH</div> <div>2-18-1895</div>		<div>9 AGE (in years last birthday)</div> <div>72 yrs</div>		
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Government Professor, Author-Ret.</div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Retired</div>		<div>11 BIRTHPLACE (County & State, or foreign country)</div> <div>Ohio</div>		<div>12 CITIZEN OF WHAT COUNTRY?</div> <div>American</div>		
<div>13. FATHER'S NAME</div> <div>Federal Government Employee</div> <div>John Joyce</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Katherine Keneavy</div>					
<div>15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>Navy 18 to 19</div>			<div>16 SOCIAL SECURITY NO.</div> <div>278-10-3850</div>		<div>17. INFORMANT</div> <div>Patient's chart</div>					
<div>18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))</div> <div>PART I. DEATH WAS CAUSED BY</div> <div>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u></div> <div>DUE TO (b) <u>Acute myocardial infarction</u></div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)</div>									<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>2 dx</div>	
<div>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>Purpura</div> <div>Avascular cell Ca - 1 dx</div>									<div>19 WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)</div>						
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour am pm 19</div>				<div>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work</div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town) (County) (State)</div>		
<div>21. I certify that (I) (this hospital) attended the deceased from 2-22, 1967, to 2-28, 1967, that (I) (we) last saw the deceased alive on 2-27, 1967, and that death occurred at 4:00 AM, from causes and on the date stated above.</div>										
<div>22a. SIGNATURE</div> <div>R. H. Sandstrom</div>					<div>M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div>			<div>22b. DATE SIGNED</div> <div>2-28-67</div>		
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>R. H. Sandstrom mb</div>					<div>22d. ADDRESS</div> <div>7701 Carroll Ave. Takoma Park</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial-transit 2-28-67</div>			<div>23b. DATE THEREOF</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Calvary Cemetery</div>			<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Youngstown, Ohio</div>		
<div>24. FUNERAL DIRECTOR</div> <div>ROBERT A. PUMPHREY, Bethesda, Maryland</div>					<div>25a. REC'D BY REGISTRAR</div> <div>MAR 8 1967</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>			

02383

CERTIFICATE OF DEATH

02376

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1401 Blair Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Max</u> First <u>Max</u> Middle <u>-</u> Last <u>Kasson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
13. FATHER'S NAME <u>Sholom</u>		14. MOTHER'S MAIDEN NAME <u>Balea</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>577-09-9920</u>	
17. INFORMANT <u>Hos & Records</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <u>4201</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> , 19 <u>66</u> , to <u>Feb 1</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Feb 1</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2/1/67</u>
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d. ADDRESS <u>8484 16th St. S.E. Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>OXON HILL MD.</u>
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASHINGTON - D.C.</u>		25a. REC'D BY REGISTRAR <u>Feb 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02384

CERTIFICATE OF DEATH

02377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>F.S. Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 da</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Chase Nursing & Conv. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Kay</u> Last <u>Kay</u>		4 DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4 July 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD</u>	9 AGE (n years last birthday) <u>83</u> yrs.
11 BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>IDA ???</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-40-176</u>	
17. INFORMANT <u>ASHLEY S. FISMAN</u> Address <u>1118 CHICKSAW DR. SILVER SPRING, MD</u>			
18 CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4200 DUE TO (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (Yes hospital) attended the deceased from <u>1950</u> , 19 to <u>Feb-2, 1967</u> , that (I) (or last saw the deceased alive on <u>2-2-1967</u> , and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leroy Robins</u>		22b. DATE SIGNED <u>2-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEROY ROBINS</u>		22d. ADDRESS <u>2480-16th St NW Wash DCB.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ONEV SHOLON CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, DC.</u>
24. FUNERAL DIRECTOR ADDRESS <u>4217-9th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>			

FOR STATE
HEALTH DEPT.

02385

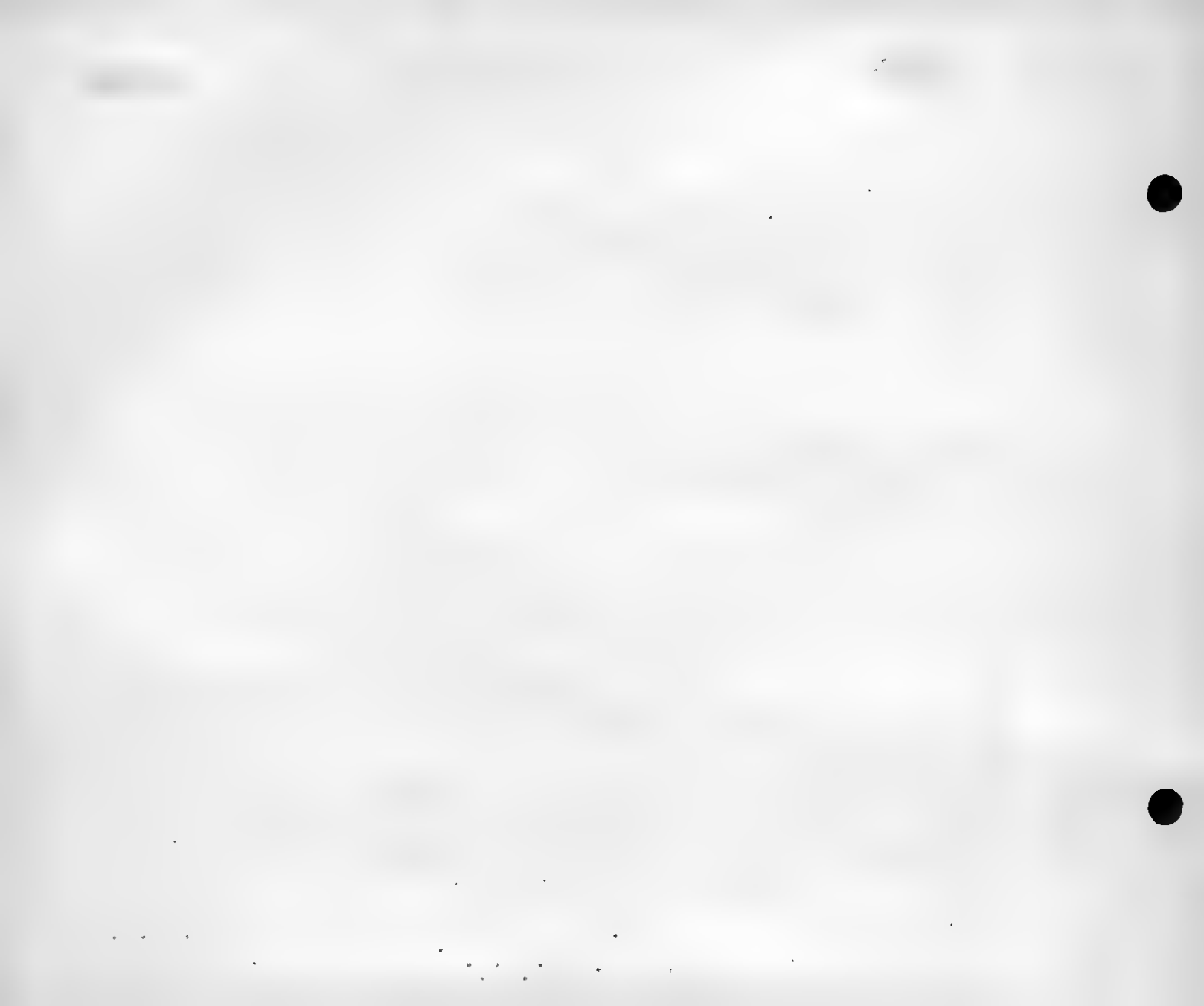
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02378

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c LENGTH OF STAY IN 1b 9 hrs		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a STATE D.C. b COUNTY Washington - N.W. c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington - N.W. d STREET ADDRESS 4414 35th ST. N.W. e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Albert James Kearney		4 DATE OF DEATH Month Day Year Feb 19 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-21-87
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired accountant		10b KIND OF BUSINESS OR INDUSTRY Navy Dep't.	11 BIRTHPLACE (State or foreign country) D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME James Kearney	
14 MOTHER'S MAIDEN NAME Eva Behrens		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Navy - - - -	
16 SOCIAL SECURITY NO 579-60-6655		17 INFORMANT Hospital Record	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) intracranial hemorrhage and DUE TO (c) monocytic leukemia			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, county, state) 2/19/1967			
22. DATE SIGNED		23a BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b DATE THEREOF 2-22-1967		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d LOCATION (City or town) (County) (State) Washington, D.C.		24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.	
ADDRESS 5130 Wisconsin Ave. N.W.		25a REC'D BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 24 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02386

02379

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
c. LENGTH OF STAY IN 1b <u>16 yrs</u>				d. STREET ADDRESS <u>600 Clayborn Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>600 Clayborn Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest Joseph Kientz</u>				4. DATE OF DEATH <u>Feb. 18, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/7/93</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Alsace, France</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>				13. FATHER'S NAME <u>EMLE KIENTZ</u>			
14. MOTHER'S MAIDEN NAME <u>UNK</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>578-03-1253</u>				17. INFORMANT <u>George Kientz</u> Address <u>See #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Arteriosclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Gangrene feet</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Nov. 1945</u> to <u>Feb. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/11, 1967</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>E.H. Aschenbach</u> M.D.				22b. DATE SIGNED <u>2/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>E.H. Aschenbach</u>				22d. ADDRESS <u>1841 Col. Rd. N.W.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>2/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEO WASH CEM</u>		23d. LOCATION (City, town, or county) (State) <u>Riggs Rd R. Geo Co MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Chambers Co. Inc.</u> ADDRESS <u>8655 Georgia Av Silver Spring MD</u>				25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>			
25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02387

CERTIFICATE OF DEATH

02380

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD # 1, Monrovia		d. STREET ADDRESS R.F.D. # 1, Monrovia	
3 NAME OF DECEASED (Type or print) Earl V. King		4. DATE OF DEATH Month Feb. Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 30 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11 BIRTHPLACE (County & State, or foreign country) Purdum, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pearl King		14. MOTHER'S MAIDEN NAME Alice Price	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 219-36-4354	
17 INFORMANT Mrs Betty Mae Barton, Monrovia, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) 5 years		INTERNAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 65 to 7/23 , 19 67 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 2/19 , 19 67 , and that death occurred at 6:30 am from causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 2/24/67	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 25, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. View		23d. LOCATION (City or Town) (County) (State) Purdum, Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE FEB 27 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02388

CERTIFICATE OF DEATH

02381

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 6 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carrol Hall Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1916 17th St. NW. d. STREET ADDRESS Washington, DC e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE THALL KINGSBURY		4. DATE OF DEATH Month Day Year FEBRUARY 20 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1882
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur P. Kingsbury		14. MOTHER'S MAIDEN NAME Carrie L. THALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. L	
17. INFORMANT Mrs. Bessie Allison Chew Chase, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE + 1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 28, 1966 , to FEB 20, 1967 , that (I) (we) last saw the deceased alive on FEB 20 1967 , and that death occurred at 8:42 AM , from the causes and on the date stated above.			
22a. SIGNATURE Henry M. Lowden		22b. DATE SIGNED FEB 20, 1967	
22c. PHYSICIAN'S NAME (Type) HENRY M. LOWDEN		22d. ADDRESS 5208 NEW WAY DR. CHEVY CHASE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-25-67	
23c. NAME OF CEMETERY OR CREMATORY Coventry Town Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Connecticut	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR BETHESDA, MARYLAND	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 24 1967	

02389

CERTIFICATE OF DEATH

02382

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c LENGTH OF STAY IN TB 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS R. J. D. #1 SHERVIEW LANE	
3 NAME OF DECEASED (Type or print) First Middle Last CARSON NATHANIEL KIRK		4 DATE OF DEATH Month Day Year FEBRUARY 14 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/9/21
9 AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORSE BREEDER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11 BIRTHPLACE (County & State, or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. KIRK		14. MOTHER'S MAIDEN NAME BERTHA Aldridge	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO None		16 SOCIAL SECURITY NO Yes	
17 INFORMANT Mrs. Esther R. Kirk		Address R. J. D. #2 Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO (b) Bleeding esophageal varices DUE TO (c) Cirrhosis of liver (alcoholic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 8 days 4 mos.			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 2-6-67, 19 to 2-14-67 that (I) (we) last saw the deceased alive on Feb 14 1967, and that death occurred at 7:40 AM, from causes and on the date stated above.			
22a. SIGNATURE Frederick Mooman M.D.		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) Frederick Mooman M.D.		22d. ADDRESS SANDY SPRINGS MED. CENTER, SANDY SPRGS.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery	23d. LOCATION (City or Town) (County) (State) Colesville, Maryland
24 FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 1967	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

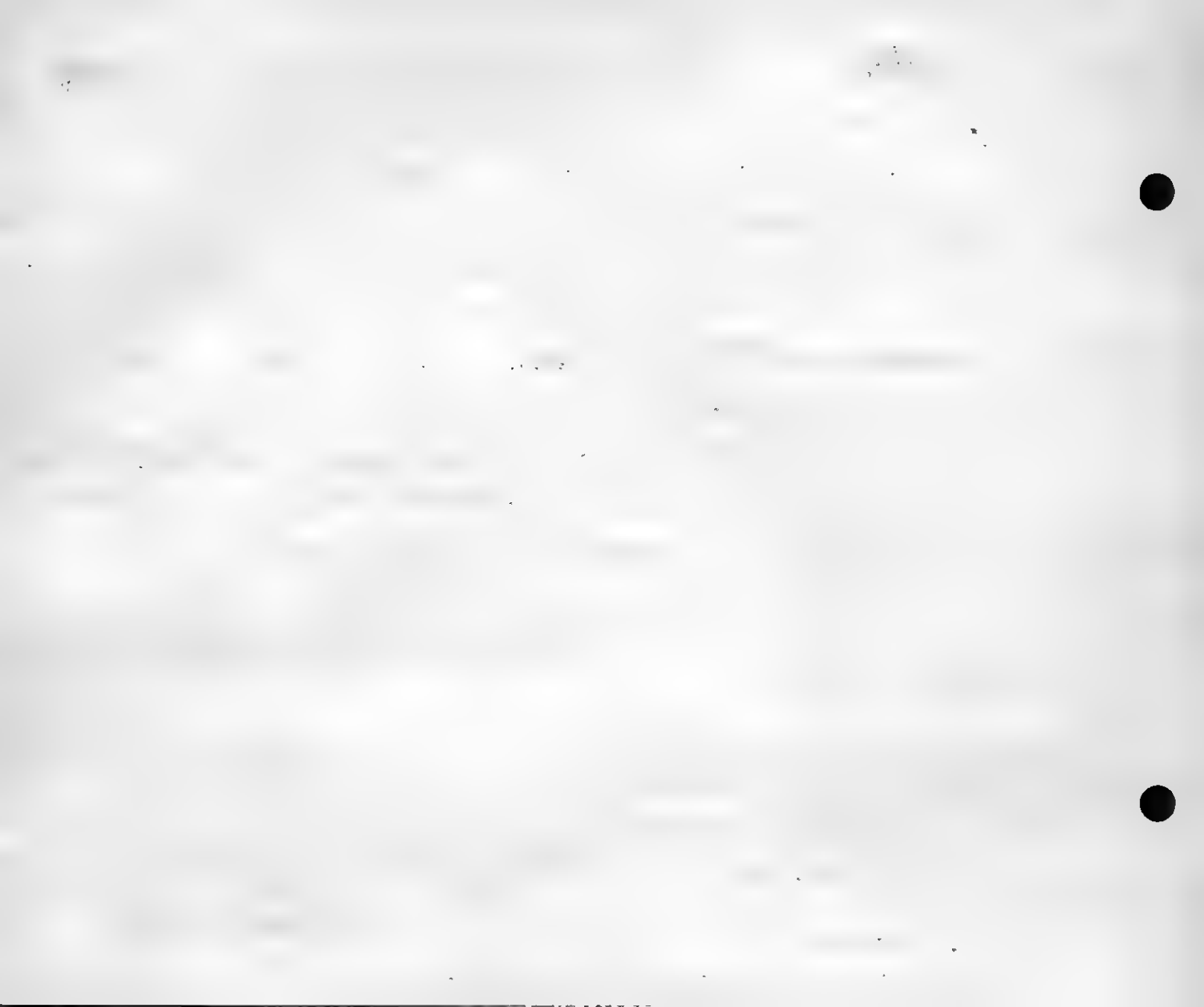
02390

02383

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b - <u>1 1/2 yr.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3204 Edgewood Rd.</u>				d. STREET ADDRESS <u>3204 Edgewood Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>David John Knapstein</u>				4 DATE OF DEATH Month Day Year <u>Feb - 2 1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 31 1920</u>	9 AGE (In years last birthday) <u>46</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Program Manager Govt. N.S.A.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. N.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John G. Knapstein</u>				14. MOTHER'S MAIDEN NAME <u>Mary Polzin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII - Korean</u>		16. SOCIAL SECURITY NO <u>395-10-1526</u>		17. INFORMANT <u>Mrs. Carol Knapstein</u> Address <u>3204 Edgewood Road Kensington, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				22. DATE SIGNED <u>Feb. 2/2/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



02391

CERTIFICATE OF DEATH

02384

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN lb <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>8302 Roanoke Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>John</u> Last <u>Kotek</u>		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>1-7-22</u>	9. AGE (In years last birthday) <u>45</u> yrs
8. <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input checked="" type="checkbox"/>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>17</u> Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Philadelphia Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steve Kotek</u>		14. MOTHER'S M.A.D.E.N. NAME <u>Mary HADZIMA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWII</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Atherosclerosis of coronary arteries</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>60</u> to <u>February 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>February 7</u> , 19 <u>67</u> , and that death occurred at <u>2:05</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>February 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>		22d. ADDRESS <u>8237 Georgia Ave. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>FEB 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SIERRA VIEW CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>MARYSVILLE, CALIF.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. INC.</u>		25a. REC'D BY REGISTRAR <u>1400 CHAPIN ST NW WASHINGTON 9, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 14 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

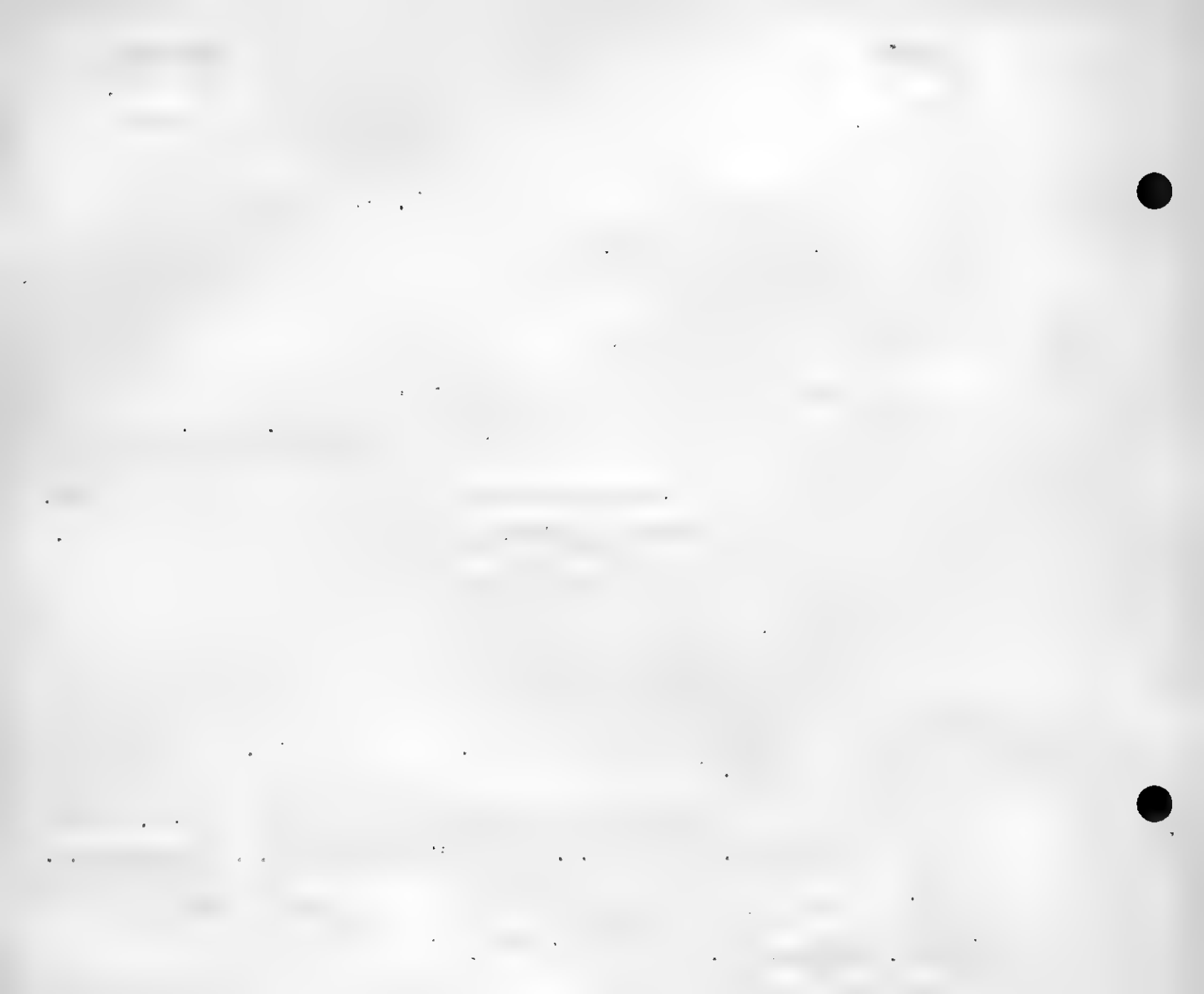
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02392

CERTIFICATE OF DEATH

02385

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> c. LENGTH OF STAY IN 1b <i>6 weeks</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll Hall Sanitarium</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>2208 Parker Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Maria</i> Middle <i>Jasnadi-</i> Last <i>Kovacs</i>				4. DATE OF DEATH Month <i>February</i> Day <i>22</i> Year <i>1967</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 29, 1888</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Miskole, Hungary</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Hungary</i>		13. FATHER'S NAME <i>Andrew Kozma De Leveld</i>				14. MOTHER'S MAIDEN NAME <i>Gizella Jesus</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Frank Kovacs</i>		18. ADDRESS <i>2208 Parker Avenue Silver Spring, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>4301</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Auricular Fibrillation</i> (c) <i>Coronary Artery Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> <i>3 mos.</i> <i>5 yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severe microcytic Anemia</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Jan.</i> , 19 <i>57</i> , to <i>Feb. 20</i> , 19 <i>67</i> , that (I) and last saw the deceased alive on <i>Feb. 20</i> , 19 <i>67</i> , and that death occurred at <i>2</i> a.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Andrew E. Fischer</i>				22b. DATE SIGNED <i>Feb. 23, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>Andrew E. Fischer, M.D.</i>				22d. ADDRESS <i>2121 P Street, N.W. Washington, D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Feb 25, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	
23d. LOCATION (City, town or county) (State) <i>Rockville, Maryland</i>							
24. FUNERAL DIRECTOR <i>E. Glen Carter</i> <i>Warner E. Pumphrey, Inc.</i>				25a. REC'D BY REGISTRAR <i>Feb 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>William Charles Juggs</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

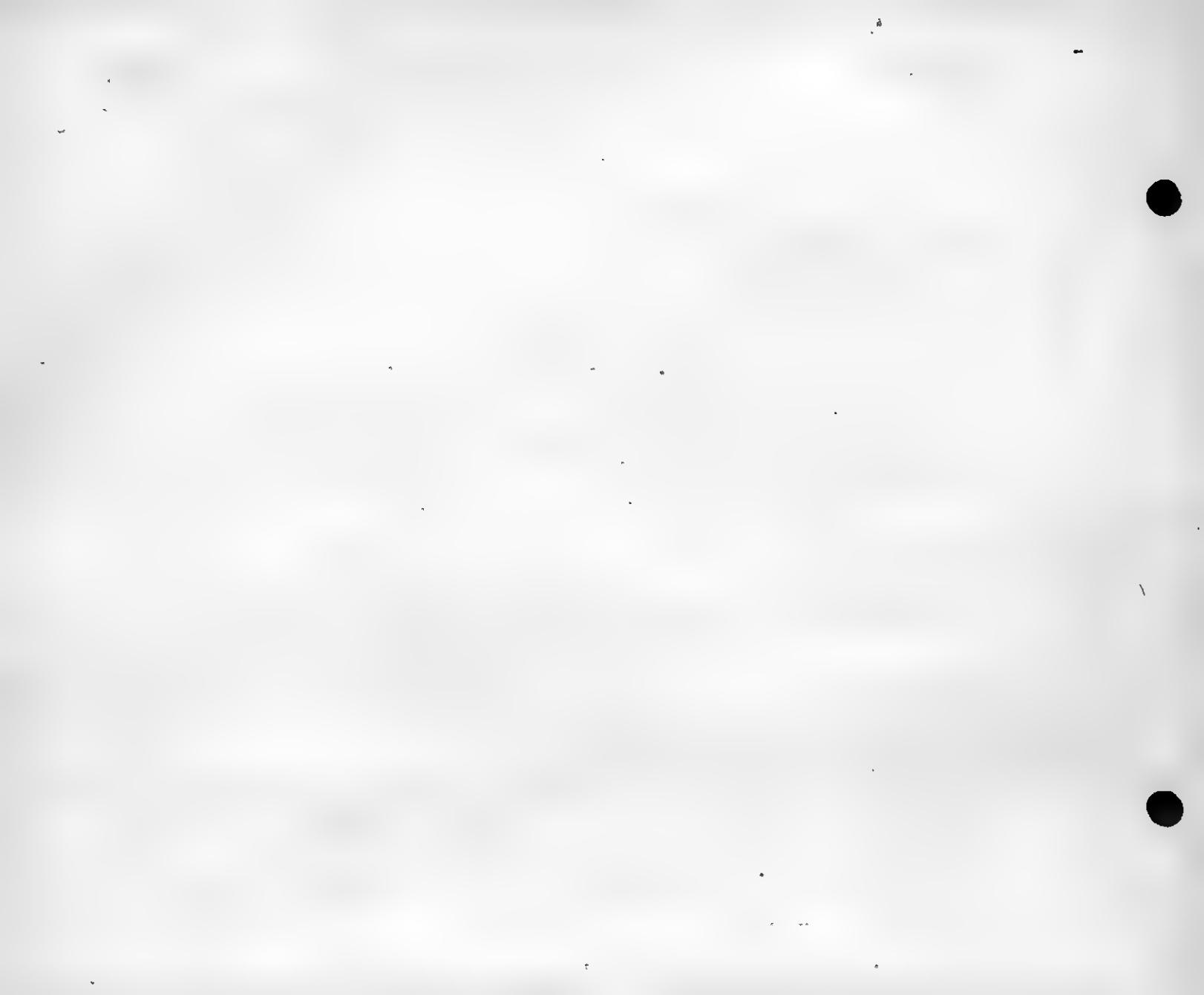
02393

CERTIFICATE OF DEATH

02386

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9023 Lindale Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Bridgetine Helen La Bau</u> First Middle Last 5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			4 DATE OF DEATH <u>Feb 1</u> 19 <u>67</u> Month Day Year 8. DATE OF BIRTH <u>1/1/1911</u> 9 AGE (in years last birthday) <u>56</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt-Retired</u> 11 BIRTHPLACE (County & State, or foreign country) <u>Penna.</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Louis O'Bot</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>578-42-2355</u> 17 INFORMANT <u>Husband - Milton La Bau</u> Address <u>Same as above</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatous</u> (b) <u>Due to Adeno Carcinoma of Lung</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> 19 <u> </u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u>, 19<u>66</u>, to <u>FEB 1</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>JAN 31</u>, 19<u>67</u>, and that death occurred at <u>8:40</u> M, from causes and on the date stated above. 22a. SIGNATURE <u>Arch L. Riddick</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>ARCH L. RIDDICK</u> 22b. DATE SIGNED <u>2/1/67</u> 22d. ADDRESS <u>1835 Egan St NW Wash DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-3-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>		24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> ADDRESS <u> </u> 25a. RECD BY REGISTRAR <u>FEB 6</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u> DATE <u> </u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02394

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; if home, give date of admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Evergreen Lane</i>		d. STREET ADDRESS <i>Evergreen Lane</i>	
3. NAME OF DECEASED (Type or print) <i>RICHARD</i> First Middle <i>La Garde</i>		4. DATE OF DEATH Month <i>February</i> Day <i>16</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10, 1883</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Army Officer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
11. BIRTHPLACE (County & State or foreign country) <i>(Indian Territory) (Nebraska)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Anatole La Garde</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN FRANCES NEELY</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>W.W.I. + W.W.II</i>		16. SOCIAL SECURITY NO. <i>577-03-0105</i>	
17. INFORMANT Address <i>MRS. Beatrice V.F. La Garde</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Thrombotic coronary occlusion (death sudden)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i>		(c) <i>with myocardial decompensation</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerosis for anemia, several years ago</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1930</i> , 19 <i>30</i> to <i>2/16</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2-16</i> 19 <i>67</i> , and that death occurred at <i>6:12</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>W.H. Lintner</i>		22b. DATE SIGNED <i>2/16/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Lintner</i>		22d. ADDRESS <i>1105 S. Washington St. Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>& Burial</i>		23b. DATE THEREOF <i>2-21-1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Va.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>FEB 24 1967</i>	

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02398

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 3625 S. Leisure World Blvd.	
3. NAME OF DECEASED (Type or print) First John Middle Harold Last Lahman		4. DATE OF DEATH Month 2 Day 9 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-1900
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Accounting	
11. BIRTHPLACE (State or foreign country) Franklin Grove, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Wilford Lahman		14. MOTHER'S MAIDEN NAME Martha Beery	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 334-07-1942A	
17. INFORMANT Medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO (b) synergistic action of alcohol and barbiturates DUE TO (c) last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased drank alcoholic beverage after taking a barbiturate medication	
20c. TIME OF INJURY Month, Day, Year 1:00 Hour 2-9 Day 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home	20f. (City or town) (County) (State) SS Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden K. Keapling M.D.		22. DATE SIGNED Feb 9, 1967	
EXAMINER'S NAME (Type) BELDEN K. KEAPLING		Address (Street, city, town, or county) 5130 Wisc. Ave. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 2-11-1967	23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	23d. LOCATION (City or town) (County) (State) Dixon, Illinois
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REG. STRAR DATE FEB 14 1967	
25b. REGISTRAR'S SIGNATURE W. J. J. J.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

100



100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02396

CERTIFICATE OF DEATH

02389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5704 Old Chester Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Louise Lansford</u>		4. DATE OF DEATH <u>2-9-67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-90</u> 9. AGE (In years last birthday) <u>76</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward E. Crockett</u>		14. MOTHER'S MAIDEN NAME <u>Pyle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-40-5171</u>	
17. INFORMANT <u>Husband-Wilkins</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC - HYPERTENSIVE</u> DUE TO (c) <u>CEREBRO-VASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>9 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>SEPT. 8, 1955</u> to <u>FEB. 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>FEB. 9, 1967</u> , and that death occurred at <u>12:01 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Angle</u>		22b. DATE SIGNED <u>9 FEB. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. ANGLE</u>		22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>FEB 17 1967</u>			

02397

CERTIFICATE OF DEATH

02390

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Route #2	
3 NAME OF DECEASED (Type or print) First Brooxxie Middle Pauline Last Layton		4 DATE OF DEATH Month 2 Day 21 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-13
9. AGE (In years lost birthday) 53 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Margaret Hatfield	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-03-6147	
17. INFORMANT George E. Layton Address Same as #		18. MEDICAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hypertension due to bone metastases DUE TO (b) Adenocarcinoma of the ovary DUE TO (c) 16 months		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) NONE	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Mar 1965 to Feb 21, 1967 , that (I) (we) last saw the deceased alive on Feb 21, 1967 , and that death occurred at 12:10 PM from causes and on the date stated above			
22a SIGNATURE Chester LeeRoy Wagstaff		22b DATE SIGNED Feb 21, 1967	
22c PHYSICIAN'S NAME (Type) Chester LeeRoy Wagstaff, M. D.		22d ADDRESS Medical Center, Sandy Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 2/24/1967	23c NAME OF CEMETERY OR CREMATORY Poplar Springs	23d LOCATION (City or Town) (County) (State) Howard Co., Md.
24. FUNERAL DIRECTOR C. M. Waltz box 241 Sykesville, Md.		25a REC'D BY REGISTRAR DATE FEB 24 1967	
25b REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

02398

CERTIFICATE OF DEATH

02391

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>909 Maplewood Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>'NMN'</u> Last <u>Lemucchi</u>		4 DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-20-99</u>
9 AGE (in years last birthday) <u>67</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brazil</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Gesualdo Lemucchi</u>		14. MOTHER'S maiden name <u>Anna Beagiole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW-I Italy</u>		16 SOCIAL SECURITY NO <u> </u>	
17 INFORMANT <u>Patient's Chart</u>		Address <u> </u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <u>163X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>Feb 25</u> , 1967, and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>James W. Throck</u> M.D.		22b DATE SIGNED <u>2-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James W. Throck</u>		22d ADDRESS <u>7717 Canellane Tak Park</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b DATE THEREOF <u>Feb 28, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	23d LOCATION (City or Town) (County) (State) <u>Wheaton, Md.</u>
24. FUNERAL DIRECTOR <u>W. J. Throck</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>	
ADDRESS <u>3603 14th Ave</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02399

CERTIFICATE OF DEATH

02392

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>1721 Kearney Street, N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Harry Adrian Leusenkamp Sr.</u>				4. DATE OF DEATH Month Day Year <u>February 23 19 67</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-21</u>	9. AGE (In years last birthday) <u>75</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		
12. CITIZEN OF WHAT COUNTRY? <u>American</u>			13. FATHER'S NAME <u>Mr. Garritt Leusenkamp</u>				
14. MOTHER'S MAIDEN NAME <u>Diana VanDyke</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO <u>579-60-2217</u>			17. INFORMANT <u>Patient's chart</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum with metastases</u> 154X DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchogenic Carcinoma with metastases</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 19 67</u> to <u>Feb 23, 19 67</u> that (I) (we) last saw the deceased alive on <u>Feb 22 19 67</u> and that death occurred at <u>2 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Boris Rabkin, M.D.</u>				22b. DATE SIGNED <u>2/23/67</u>		22c. PHYSICIAN'S NAME (Type) <u>BOBIS RABKIN MD</u>	
22d. ADDRESS <u>1019 Univ. Blvd East S.S.</u>				22e. REC'D BY REGISTRAR <u>25a. REGISTRAR'S SIGNATURE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				25. DATE <u>FEB 27 1967</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02400

CERTIFICATE OF DEATH

02393

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 50 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2203 Lake Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lesley McCollough Lewis		4. DATE OF DEATH Month Day Year February 18 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1899
9. AGE (in years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton H. Lewis		14. MOTHER'S MAIDEN NAME Lucy Callis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 260-18-7281	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suspected Bacterial Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Pyelonephritis DUE TO (c) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH 8 hours 2 months 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 30, 1966 , to Feb. 18, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 18, 1967 , and that death occurred at 7:25 M. from causes and on the date stated above.			
22a. SIGNATURE Leonard H. Brubaker M.D.		22b. DATE SIGNED 19 Feb. 1967	
22c. PHYSICIAN'S NAME (Type) Leonard H. Brubaker, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-22-1967	23c. NAME OF CEMETERY OR CREMATOR NEW CATHEDRAL	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR J. Walter Conklin ADDRESS 5444 BELAIR RD.		25a. REC'D BY REGISTRAR FEB 23 1967	25b. REGISTRAR'S SIGNATURE <i>J. Walter Conklin</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
20 M 1967



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02401

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02394

1 PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1 24 McKay Rd.	
3. NAME OF DECEASED (Type or print) First Moody Middle S. Last Lewis		4 DATE OF DEATH Month 2 Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 60 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance adjuster		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11 BIRTHPLACE (State or foreign country) Gilbert South Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George Rufus LEWIS		14 MOTHER'S MAIDEN NAME Anna I. MILLER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 233 14 0769	
17 INFORMANT Holy Cross Hospital		Address 1500 Forest Glen Rd. S.S.Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCALITY (City or town) (County) (State) BLADENSBURG MARYLAND	
23b. DATE THEREOF 27 FEB 1967		23c. LOCALITY (City or town) (County) (State) BLADENSBURG MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		22. DATE SIGNED 2/23/1967	

FOR STATE
HEALTH DEPT.

02402

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02395

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN b. <u>2 hrs</u>	
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Chevy Chase</u>		d. STREET ADDRESS <u>7311 Summit Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia Brown Lewis</u>		4. DATE OF DEATH <u>Feb 13 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/8/1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hill Dept Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Emily Leaf</u> Address <u>3030 University Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
22. DATE SIGNED <u>2/14/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 2-15-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02403

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02396

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Res. den. before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hospital		d. STREET ADDRESS 5726 Eastpines Drive	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Month February Day 1 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-67
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Douglas Barnett		14. MOTHER'S MAIDEN NAME Shirley Ann Lincoln	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Josephine Lincoln-Riverdale, Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 762.5 IMMEDIATE CAUSE (a) Anoxia DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) Failure of lungs to expand DUE TO (c) Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE Lester Mohr		22b. DATE SIGNED 2/1/67	
22c. PHYSICIAN'S NAME (Type) Lester Mohr, M.D.,		22d. ADDRESS 7600 Carroll Ave., Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF Feb 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital		23d. LOCATION (City or Town) (County) (State) Takoma Park, Montgomery, Md.	
24. FUNERAL DIRECTOR H. Nelson 7600 Carroll Ave., Takoma Park, Md.		25a. REC'D BY REGISTRAR DATE FEB 6 1967	
25b. REGISTRAR'S SIGNATURE <i>H. Nelson</i>			

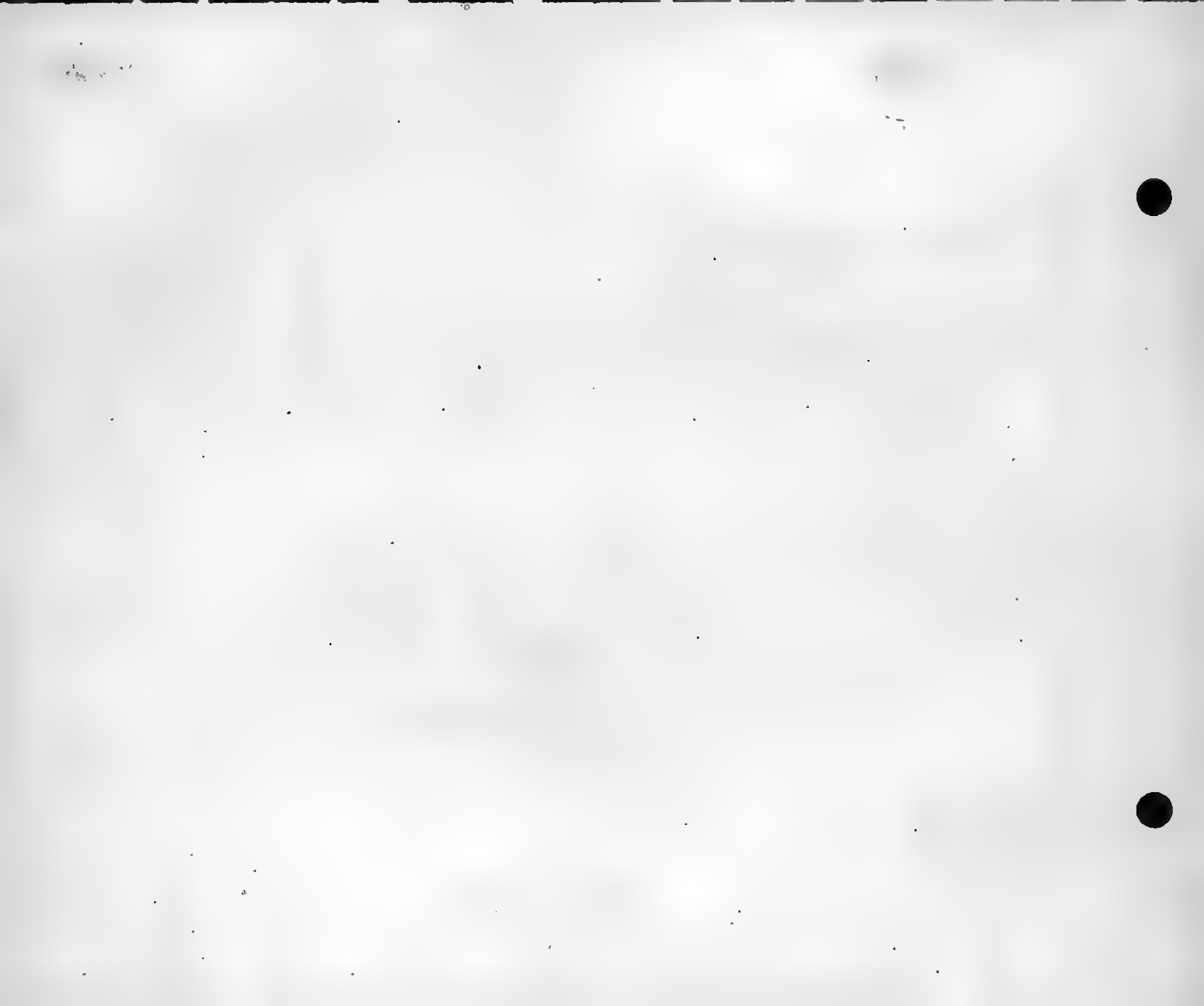
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Classified by Medical Examiner: James R. Coleman MD. 2/21/67

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02404						CERTIFICATE OF DEATH						02397	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN b <u>1 mo. 22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>?</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>5815-6th ST N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ARCHIBALD</u> First <u>LINDSEY</u> Middle <u>O</u> Last <u>LINDSEY</u>			4. DATE OF DEATH <u>2</u> - <u>21</u> 19 <u>67</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>12-28-73</u>			9. AGE (In years last birthday) <u>93</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CH. PATENT EXAMINER - US Govt</u>						11b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK STATE</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>				
13. FATHER'S NAME <u>DANIEL LINDSEY</u>						14. MOTHER'S MAIDEN NAME <u>MIRETTA RILLING</u> Address <u>FAIRFIELD, PENNA</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>578-62-3800</u>			17. INFORMANT <u>Ralph E. Lindsey - Box 177 Rt #2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO <u>years.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper respiratory infection</u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 Mins.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from <u>1/3</u> , 19 <u>67</u> , to <u>2/21</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>James R. Coleman MD</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2/21/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>						22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>2/24/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>			23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u>				
24. FUNERAL DIRECTOR <u>W. Chambers - 3655 GA. AV. MD.</u>						25a. REC'D BY REGISTRAR <u>FEB 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>W. Chambers</u>				



Cleared with Dr. Reap for signing of Certificate by Dr. Goodman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02405

CERTIFICATE OF DEATH

02398

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>901 Nora Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Lippman</u> Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-17</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optometrist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EYES</u>	
11. BIRTHPLACE (County & State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Gottlieb Lippman</u>		14. MOTHER'S MAIDEN NAME <u>DORA ROCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII Army</u>		16. SOCIAL SECURITY NO <u>578-059192</u>	
17. INFORMANT <u>Brother - Meyer E. Lippman</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> to <u>Feb. 24</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>67</u> , and that death occurred at <u>7:35</u> AM, from causes and on the date stated above			
22a. SIGNATURE <u>Nelson G Goodman</u>		22b. DATE SIGNED <u>2/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NELSON G GOODMAN</u>		22d. ADDRESS <u>2121 PENNA. AVE, NW D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo Wash. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ST. N. W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>FEB 27 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
item 2 Film G586 2/27/67 mh

02406

CERTIFICATE OF DEATH

02399

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN IS 35 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS Bethesda, Silver Spring Connalescent Home, 8700 Jones Mill Road 134 Elmwood Dr.	
3. NAME OF DECEASED (Type or print) Stephen Andrew LOFTUS		4 DATE OF DEATH Month February Day 8 Year 19 67	
5 SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1884
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. C.O.T.	
11 BIRTHPLACE (County & State, or foreign country) Denver Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Henry Loftus		14. MOTHER'S MAIDEN NAME Mary Buckley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Spanish American		16 SOCIAL SECURITY NO. 030 26 4130	
17 INFORMANT Washington Address D.C.		Mrs. Rosemary Thompson, 1525 H St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY 491X IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Jan. 4 , 19 67 , to Feb. 8 , 1967, that he (we) last saw the deceased alive on Feb. 8 , 19 67 , and that death occurred at 230A M, from causes and on the date stated above			
22a SIGNATURE F. H. O'CONNELL		22b DATE SIGNED 9 February 1967	
22c PHYSICIAN'S NAME (Type) F. H. O'CONNELL, M. D.		22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Feb 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24 FUNERAL DIRECTOR Warner E. Humphrey ADDRESS Maryland Funeral Home, 8434 Georgia Ave., Silver Spring		25a. REC'D BY REGISTRAR DATE FEB 16 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

02407 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
02400													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>1 mo. 26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3217 McComas Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Chemung Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elmira</u> d. STREET ADDRESS <u>382 South Hampton Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>E. D.</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1967</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 14, 1886</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Carl Long</u> Address <u>3217 McComas Avenue Kensington, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause pertinent to the death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Inter-vascular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Exacerbated atherosclerosis</u> (b) (c)												INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> 19 <u>66</u> to <u>2/11</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>67</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>R. S. Williams</u>				22b. DATE SIGNED <u>2/11/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>R. S. WILLIAMS</u>				22d. ADDRESS <u>35 NEW YORK AVE. NW</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>				23b. DATE THEREOF <u>Feb 14, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Elmira, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. Glen Carter</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>FEB 16 1967</u>	
Warner E. Pumphrey, Inc. Silver Spring, Md.													

02408

CERTIFICATE OF DEATH

02401

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>31 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1529 Dale Drive</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>John William Lyles</u>		4. DATE OF DEATH <u>February 26, 1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 3, 1899</u>	9 AGE (In years last birthday) <u>67</u> yrs
8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive (Owner)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Serv. Sta.</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Union, South Carolina</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>William J. Lyles</u>	
14 MOTHER'S MAIDEN NAME <u>Nora BEVIS</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes World War I</u>	
16 SOCIAL SECURITY NO. <u>578-01-5187</u>		17 INFORMANT <u>Josephine Lyles</u> Address <u>1529 Dale Dr., S. S., Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadaver Decomposition</u> 260X DUE TO <u>Arteriosclerosis</u> (b) <u>?</u> DUE TO <u>Exhaustion</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , to <u>27 Feb, 1967</u> , that (I) (we) last saw the deceased alive on <u>27 Feb, 1967</u> , and that death occurred at <u>9:42 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William D. And</u>		22b. DATE SIGNED <u>4/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>		22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter & Son Inc. 8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAR 2 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02409

CERTIFICATE OF DEATH

02402

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>47</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DC WASHINGTON</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>MAGAZINE</u> Last <u>MAGAZINE</u>		4 DATE OF DEATH Month <u>FEB.</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-90</u>
10a. USUAL OCCUPATION ON (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Russia</u>
13 FATHER'S NAME <u>Morris Magazine</u>		14. MOTHER'S MAIDEN NAME <u>Beyla</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	17. INFORMANT <u>Samuel Magazine, 8910 Woodland Dr. S.S.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO (b) <u>Adenocarcinoma of Colon</u> DUE TO (c) <u>9 mos.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1966</u> , to <u>2/3, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/3, 1967</u> , and that death occurred at <u>11:35 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>2/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Ch., Virginia</u>
24 FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25a. REC'D BY REGISTRAR <u>St. N.W. Wash. D.C. FEB 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02403

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN TB <u>years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15301 Avery Rd.</u>		d. STREET ADDRESS <u>15301 Avery Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Lewis, Edward. Magruder</u>		4 DATE OF DEATH Month <u>Feb</u> - Day <u>8</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/25/1878</u>
9 AGE (In years lost birthday) <u>88</u> yrs		10 IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>William</u>		14 MOTHER'S MAIDEN NAME <u>William</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Lacey Magruder - Item #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Suoruden</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02411					02404				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u> <u>3000 McComas Ave.</u>					d. STREET ADDRESS <u>3900 Conn. Ave. N.W.</u> <u>Apt. 402G</u>				
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>H.</u> Last <u>Martin, Sr.</u>					4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1967</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/1/81</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical equipment inspector-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Railway</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kenneth H. Martin, Sr.</u>		18. ADDRESS <u>4104 Crispin way Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>									
Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerosis</u>									
a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>2-1-20</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2-1-8</u> 19 <u>67</u> , and that death occurred at <u>7:45</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u> M.D.									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>J. H. Fitzgerald</u>									
22d. ADDRESS <u>3750 Reservoir Rd. N.W.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>									
23b. DATE THEREOF <u>2/22/67</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>									
23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Jones Co.</u>									
25a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington, D.C.</u>									
25b. REGISTRAR'S SIGNATURE <u>FEB 21 1967</u>									

02412

CERTIFICATE OF DEATH

02405

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium and Hospital</u>		d. STREET ADDRESS <u>5016 Druid Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Theodore</u> Last <u>Mattern</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1898</u>
9. AGE (in years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Platemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Engraving</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rush, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Mattern</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>577-10-4410</u>	
17. INFORMANT <u>Elsie Mattern</u>		Address <u>5016 Druid Drive Kensington, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO (b) <u>Chronic Arteriosclerotic Valvular Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Thrombosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16, 1967</u> to <u>Feb 16, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>2-16-1967</u> , and that death occurred at <u>11 P.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>P. P. Andrews</u>		22b. DATE SIGNED <u>11-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. PANDREWS M.D.</u>		22d. ADDRESS <u>4201 Fessenden St N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner Pumphrey, Inc. 8434 Georgia Ave., S.S., Md.</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		DATE <u>FEB 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

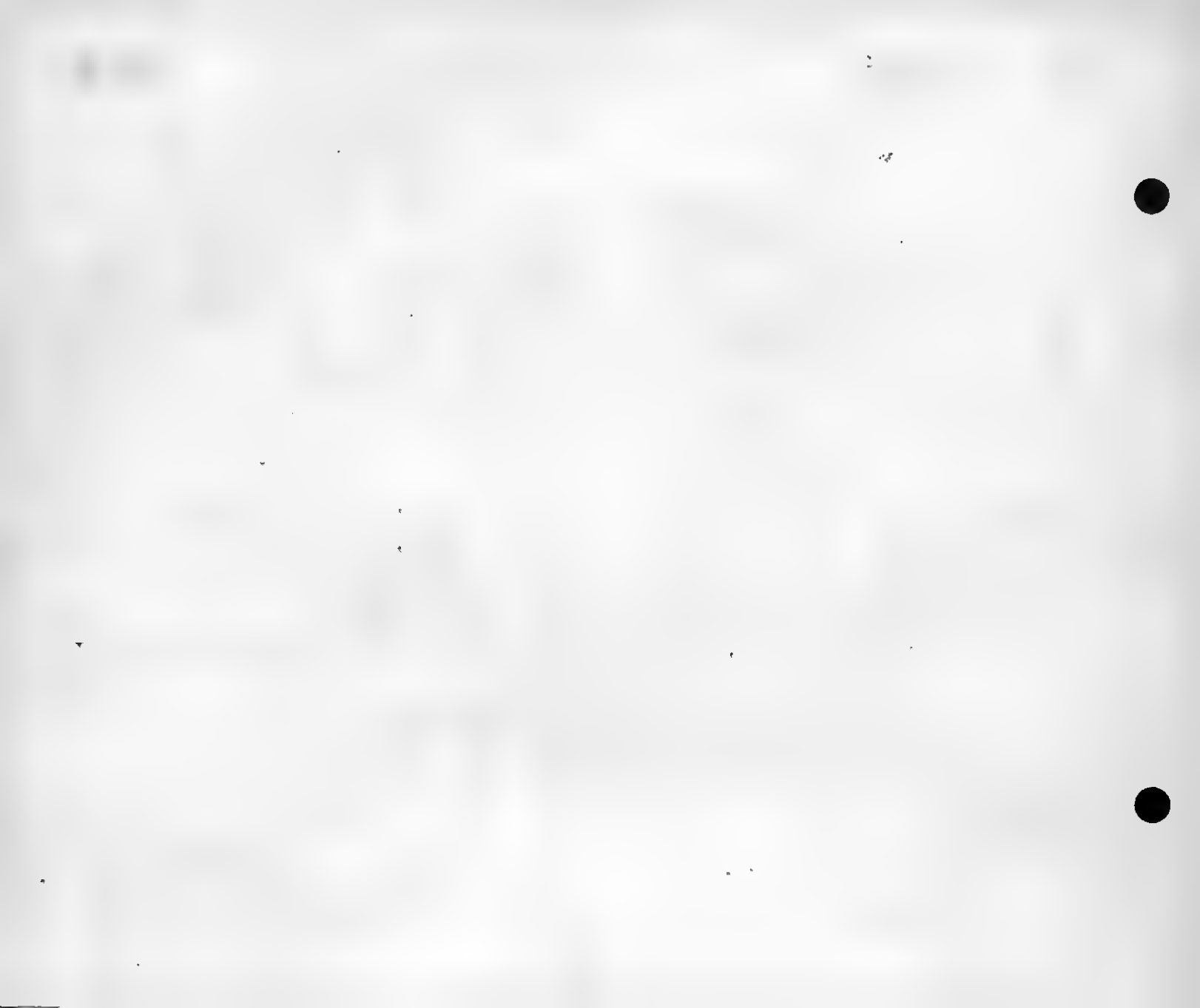
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02406

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <u>MARYLAND</u> b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>DOA</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d STREET ADDRESS <u>4325 Mabel Hall Rd</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>HAZEL AGNES M^c Dougle</u>				4 DATE OF DEATH Month Day Year <u>Feb 13 1967</u>			
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>FEB-10-1893</u>	9 AGE (In years last birthday) <u>74</u> yrs	10 IF UNDER 1 YEAR Months Days		11 IF UNDER 24 HRS Hours Min.
10a USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11 BIRTHPLACE (State or foreign country) <u>WORCESTER, MASS</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George COLEMAN MONTAGUE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA JANE WORTH</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>220-44-7949</u>		17 INFORMANT <u>MRS. EDWIN W BOWEN</u>		Address <u>FAIRWAY HILLS MD</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis, left</u> DUE TO Coronary arteriosclerosis, severe CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Primary Carcinoma, head of pancreas with moderate liver metastases</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>2/13/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b DATE THEREOF <u>2-16-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		23d LOCATION (City or Town) (County) (State) <u>BALTO MD</u>	
24 FUNERAL DIRECTOR <u>H W JENKINS & SONS Co. 4905 York Rd. BALTO, MD</u>				25a REC'D BY REGISTRAR <u>DATE FEB 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

02414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02407

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a <u>Maryland</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp.</u>		d STREET ADDRESS <u>8410 Navaho Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Mary Regina McKenna</u>		4 DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-15-12</u>
9 AGE (In years last birthday) <u>54</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b KIND OF BUSINESS OR INDUSTRY <u>A.I.L. CIO</u>	
11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Murphy</u>		14 MOTHER'S MAIDEN NAME <u>Mary Kane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u> </u>	
17 INFORMANT <u>Daughter</u>		Address <u>Hyatts, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull with massive</u> <u>900.0</u> DUE TO (b) <u>intracranial hemorrhage</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased fell down stairs and injured her head</u>	
20c TIME OF INJURY Month Day, Year <u>3:15</u> <u>2-18</u> <u>1967</u> Hour <u>3:15</u> pm	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home farm factory street office bldg. etc.) <u>Home</u>	20f (City or town) (County) (State) <u>Hyattsville Pr. Geo. Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>Feb. 19, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u> </u>	
23a BURIAL OR CREMATION <u>BURIAL</u> (Specify)	23b DATE THEREOF <u>2/23/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arl. Nat. Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>rt. Myer, Va.</u>
24 FUNERAL DIRECTOR <u>Lee Funeral Home 300-4th St.</u>		ADDRESS <u>Wash. D.C.</u>	
25a DECEASED BY REG. STAMP DATE <u>FEB 27 1967</u>		25b REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02415

CERTIFICATE OF DEATH

02408

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b University Nursing Home			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5917 4th St., NW d. STREET ADDRESS 5917 4th St., NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Helen Marguerite McLachlen First Middle Last			4. DATE OF DEATH Month Day Year Feb 19 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890 8/6/1890	9. AGE (in years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. clerk (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Wood			14. MOTHER'S MAIDEN NAME MARGARET EL LEAVY Margaret Leavy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-68-1064	17. INFORMANT SILVER SPRING, MD. ANNE W. EVANS 8716 COLESVILLE RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Carcinoma of Rectum DUE TO (c) 8 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH 8 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1966 , to Feb 1967 , that (I) (we) last saw the deceased alive on 15 Feb 1967 , and that death occurred at 8:45 M, from causes and on the date stated above.					
22a. SIGNATURE Merton L. White M.D.		22b. DATE SIGNED 20 Feb 67	22c. PHYSICIAN'S NAME (Type) Dr. Merton L. White		
22d. ADDRESS 99k 9911 Georgia Ave., S. S., Md.		22e. REC'D BY REGISTRAR Francis J. Collins			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-22-67	23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY	23d. LOCATION (City or Town) WASHINGTON	(County) (State) D.C.
24. FUNERAL DIRECTOR FRANCIS J. COLLINS		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02416

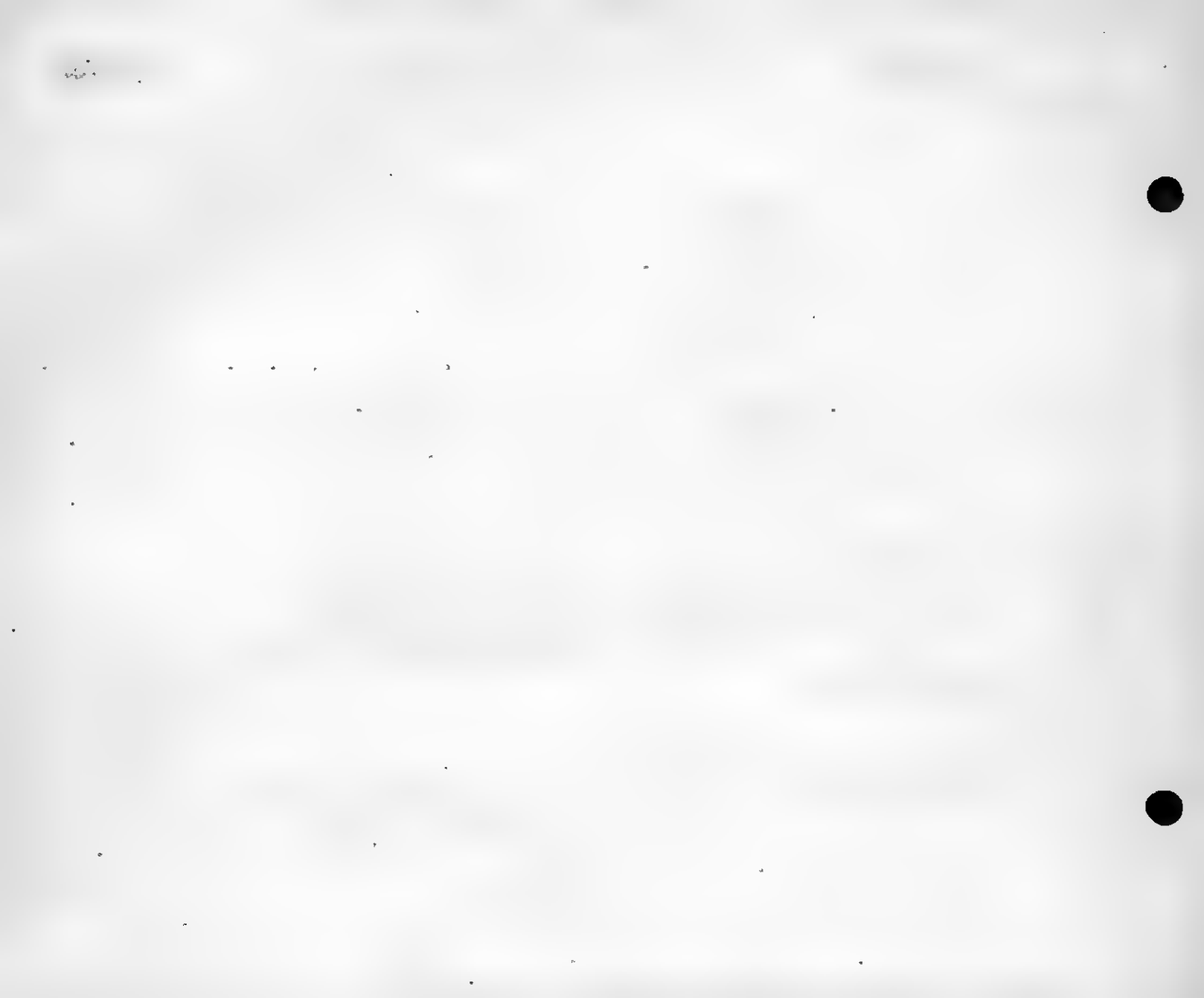
CERTIFICATE OF DEATH

02409

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN ib years Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5914 Melvern Drive		d. STREET ADDRESS 5914 Melvern Drive	
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED K. McMANUS		4. DATE OF DEATH Month Day Year Feb. 22, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1896
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME James G. Keene	
14. MOTHER'S MAIDEN NAME Susan I. Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 579-48-8201		17. INFORMANT Son James R. Pierce Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 7 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT. 1956 to FEB. 22, 1967 , that (I) (was) lost saw the deceased alive on FEB. 21, 1967 , and that death occurred at 2:30 AM , from causes and on the date stated above			
22a. SIGNATURE Leo M. Curtis		22b. DATE SIGNED 2-22-67	
22c. PHYSICIAN'S NAME (Type) LEO M. CURTIS		22d. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-24-67	23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Upperville, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 24 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02417

CERTIFICATE OF DEATH

02410

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9224 Piney Branch Rd. S.S. Md				d. STREET ADDRESS 9224 PINEY BRANCH RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle NONE Last MENZE				4. DATE OF DEATH Month FEB Day 28 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 10 1878		9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SLDG SUPERINTEND		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) WASH DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY MENZE				14. MOTHER'S MAIDEN NAME DORA VOIGT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-46-9626		17. INFORMANT WIFE EMMA MENZE 9224 PINEY BRANCH RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CEREBRO VASCULAR ACCIDENT DUE TO (c) HYPERTENSIVE VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 4 YRS 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE, 1963 to 2/28, 1967 , that (I) (we) last saw the deceased alive on 2/27, 1967 , and that death occurred at 9 P.M. from causes and on the date stated above.							
22a. SIGNATURE Henry Stout MD				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/28/67	
22c. PHYSICIAN'S NAME (Type) HENRY W STOUT MD				22d. ADDRESS 10011 GEORGIA AVE SILVER SPRING			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW DC				25a. RECEIVED BY REGISTRAR DATE MAR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02418

CERTIFICATE OF DEATH

02411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b. <u>7/7/67 - 7/19/67</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PALMER PARK</u> d. STREET ADDRESS <u>8122 PENBROOK PLACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA R. MINOVITZ</u> First Middle Last				4. DATE OF DEATH <u>FEB 19 1967</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/20/20</u> 9. AGE (In years last birthday) <u>46</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>PEENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL MICHAELSON</u>				14. MOTHER'S MAIDEN NAME <u>SUZANNE HEGADUSH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JACOB MINOVITZ - PALMER, MD.</u> Address <u>5122 - PENBROOK, PL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>364X</u> <u>Gravopneumonia</u> DUE TO (b) <u>Landry's Ascending Paralysis</u> DUE TO (c) <u>Guillain-Barre Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-8</u> , 19 <u>67</u> , to <u>2-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-18</u> , 19 <u>67</u> , and that death occurred at <u>5:50</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Morton A. Itzhak</u>				22b. DATE SIGNED <u>2-19-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Morton A. Itzhak, M.D.</u>	
22d. ADDRESS <u>9205 - New Hampshire Ave Silver Spring, Md.</u>				22e. REC'D BY REGISTRAR <u>Charles J. Jones</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-21-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Synagogue</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Md.</u>	
24. FUNERAL DIRECTOR <u>Goldberg R.H.</u>				25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	
25c. ADDRESS <u>4217 - 9th St. N.W.</u>				25d. DATE <u>FEB 23 1967</u>		25e. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02419

CERTIFICATE OF DEATH

02412

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Md 20762</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>Route # 2</u>	
3 NAME OF DECEASED (Type or print) <u>George</u> First <u>W</u> Middle <u>Mooney Sr.</u> Last		4 DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>19 67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-2-11</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <u>Elect. tech.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Elec.</u>	9. AGE (In years) <u>55</u> yrs. IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.
11 BIRTHPLACE (County & State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George J. Mooney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Maroney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>153-05-7354</u>	
17. INFORMANT <u>George W. Mooney, Jr.</u>		Address <u>Same as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <u>163X</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Pulmonary Carcinoma with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>widespread metastasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3/1/65</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2</u> , 19 <u>67</u> , to <u>Feb 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 19 <u>67</u> , and that death occurred at <u>1015 Spring Street, S. S., Mont Md</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin L. Holkin</u> M.O.		ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Feb 2, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>MARVIN L. HOLKIN, M.D.</u>		22d. ADDRESS <u>1015 Spring Street, S. S., Mont Md</u>	
23a. BURIAL, CREMATION, REMOVAL, etc. <u>Removal</u>	23b. DATE THEREOF <u>2-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	23d. LOCATION (City or Town) (County) (State) <u>Lambertville, New Jersey</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	25a. RECEIVED BY REGISTRAR <u>1967</u>
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02420

02413

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) National Institutes of Health The Clinical Center, Bethesda, Md. 20014				d. STREET ADDRESS 6410 Elliot Place	
3. NAME OF DECEASED (Type or print) Vaughn		First Ara		Last Morrison	
4. DATE OF DEATH February 11 19 67		Month February		Day 11	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 25 December 1923		9. AGE (In years last birthday) 43		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Meats		11. BIRTHPLACE (County & State, or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Grover Morrison		14. MOTHER'S MAIDEN NAME Edna Terrio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1943-46		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Gastroenteritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myeloblastic Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 6 Days 13 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from 20 January 1967 , to 11 February 1967 , that (X) (we) last saw the deceased alive on 11 February 1967 , and that death occurred at 3:30 , from the causes and on the date stated above.					
22a. SIGNATURE <i>I. David Goldman</i>		22b. DATE SIGNED 11 February 1967		22c. PHYSICIAN'S NAME (Type) I. David Goldman, MD.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. REC'D BY REGISTRAR FEB 16 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
23d. LOCATION (City, town or county) Arlington, Virginia		23e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc. Silver Spring, Md.					

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02421

CERTIFICATE OF DEATH

02414

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON c. LENGTH OF STAY IN 1b 2 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10213 Sutherland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LISETTA BECKER MUTH				4. DATE OF DEATH Month Day Year 2 12 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/3/1893	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Essex Co., New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Becker				14. MOTHER'S MAIDEN NAME LENA BECKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 265-66-8813		17. INFORMANT Richard Muth-10213 Sutherland Rd., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum cell Sarcoma 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1960 to Feb 12, 1967 , that (I) (we) last saw the deceased alive on Feb 12, 1967 , and that death occurred at 1:20 PM from the causes and on the date stated above.							
22a. SIGNATURE Max G. Sherer				22b. DATE SIGNED Feb 12, 1967			
22c. PHYSICIAN'S NAME (Type) MAX G. SHERER MD				22d. ADDRESS 800 Pershing Drive Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/15/1967		23c. NAME OF CEMETERY OR CREMATORY CLINTON CEMETERY		23d. LOCATION (City, town or county) (State) IRVINGTON NEW JERSEY	
24. FUNERAL DIRECTOR HYSONG'S FUNERAL HOME				25a. REC'D BY REGISTRAR Charles Judge			
25b. REGISTRAR'S SIGNATURE Charles Judge				DATE FEB 14 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Inform. taken from b 02422 Item 9 Film G386 2/28/67											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 7307 Riggs Rd #301				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myers			Middle			Last Myers			4. DATE OF DEATH Month February Day 15 Year 1967		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1967 February 14 1967		9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wilfred Irving Myers						14. MOTHER'S MAIDEN NAME Geneva Carol Mullens					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother			Address Hyattsville, Md 7307 Riggs Rd		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrops Fetalis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemolytic disease of newborn DUE TO (c) Rh incompatibility										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-15, 1967, to 2-15, 1967, that (I) (we) last saw the deceased alive on 2-15-1967 and that death occurred at 2:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Melvin W. Sandmeyer						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-15-67	
22c. PHYSICIAN'S NAME (Type) Melvin W. Sandmeyer						22d. ADDRESS 1106 Spring St. Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler						1331 Rockville Address like Rickville, Maryland		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

MEDICAL CERTIFICATION

02423

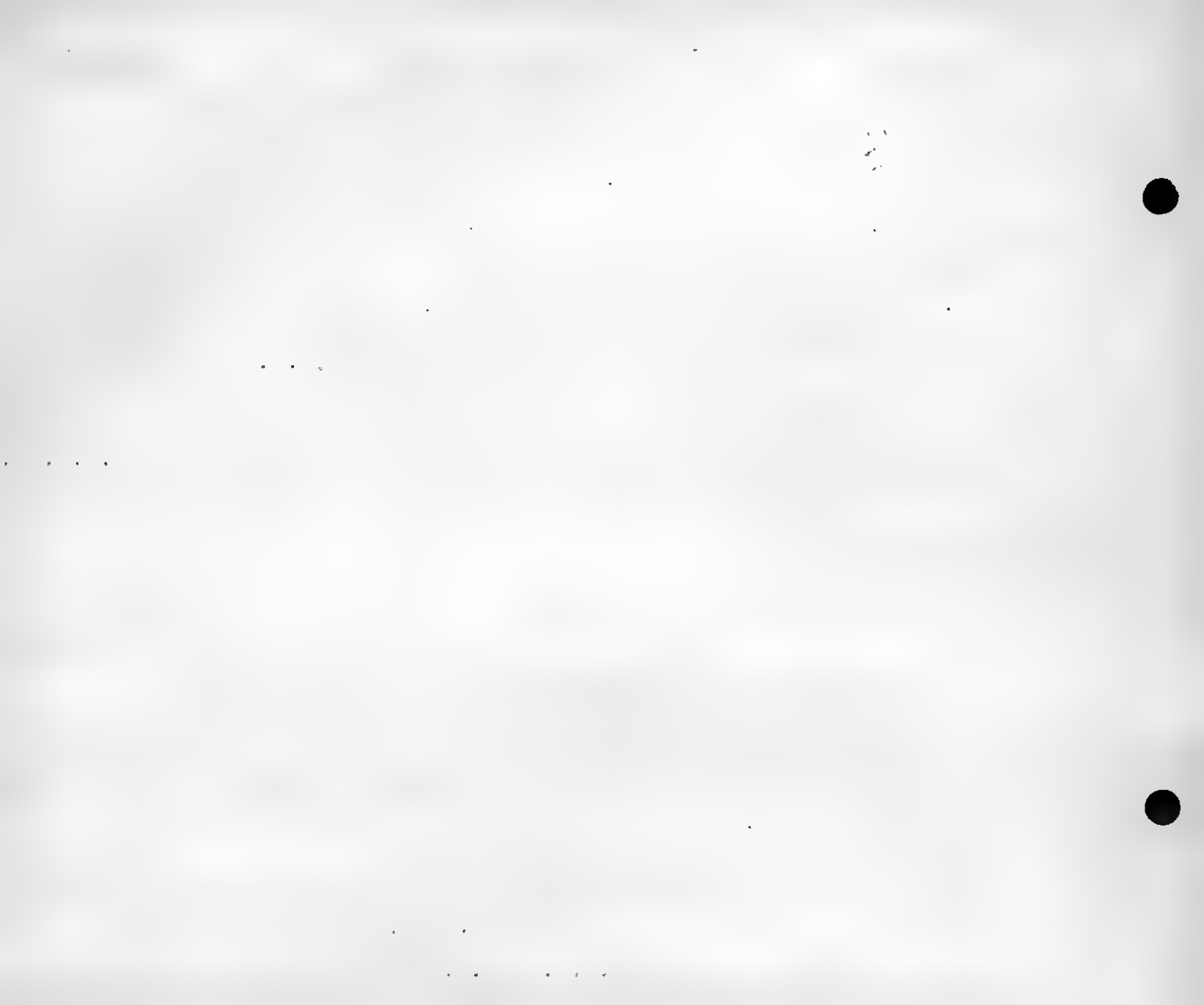
CERTIFICATE OF DEATH

02416

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return a carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Checked by Medical Examiner

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. + Hosp</u>		e. STREET ADDRESS <u>1204 De Vere Drive</u>	
3. NAME OF DECEASED (Type or print) <u>IRVING THEODORE NEEDLE</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING SUPPLIES</u>	9. AGE (In years last birthday) <u>44</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Needle</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Brenner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>579-16-4595</u>	
17. INFORMANT <u>Gilbert Needle</u>		Address <u>10810 Childs St. S.S.Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <u>1201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary</u> DUE TO (b) <u>occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 min.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , to <u>FEB 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>FEB. 6, 1967</u> , and that death occurred at <u>_____</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Arthur S. Bresler</u>		22b. DATE SIGNED <u>FEB- 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER, MD</u>		22d. ADDRESS <u>10881 LOCKWOOD DR. S.S.M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u>	23d. LOCATION (City or town) (County) (State) <u>Falls Church, Va.</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25a. REC'D BY REGISTRAR <u>5.8.14 1967</u>	
ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02424

CERTIFICATE OF DEATH

02417

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 388 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 1025 West Washington Street	
3. NAME OF DECEASED (Type or print) First Lydia Middle Mae Last Nelson		4. DATE OF DEATH February 13 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5 May 1923
9. AGE (n years last birthday) 44		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Leonard		14. MOTHER'S MAIDEN NAME Flossie Searles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 292-32-4779	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Pulmonary Metastases DUE TO (c) Adrenal Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 months 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that H (this hospital) attended the deceased from 21 January, 1966 , to 13 Feb., 1967 , that H (we) last saw the deceased alive on 13 Feb., 1967 , and that death occurred at 7:35 M. from causes and on the date stated above.			
22a. SIGNATURE M. Terry McEnany MD		22b. DATE SIGNED 1967 13 February	
22c. PHYSICIAN'S NAME (Type) M. Terry McEnany, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-14-67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City or Town) (County) (State) Painesville, Ohio
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 17 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02425

CERTIFICATE OF DEATH

02418

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hospital		d. STREET ADDRESS 13228 Glenhill Road	
3 NAME OF DECEASED (Type or print) First Middle Last Jennifer Ann Newton		4. DATE OF DEATH Month Day Year February 15, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1967
9. AGE (In years last birthday) yrs. 10		10. IF UNDER 24 HRS Months Days Hours Mins 10 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Michael Francis Newton		14. MOTHER'S MAIDEN NAME Linda Lorraine Joseph	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a SIGNATURE Harold F. Fenck M.D.		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Harold Fenck, M.D.		22d ADDRESS 11825 New Hampshire Ave., Silver Spring Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF Feb. 16, 1967	23c NAME OF CEMETERY OR CREMATORY Wash. San & Hospital	23d LOCATION (City or Town) (County) (State) 7600 Carroll Ave., Mont.
24. FUNERAL DIRECTOR J. Roughcorn 7600 Carroll Ave., Takoma Park, Md.		25a REC'D BY REGISTRAR 2-16-67	25b REGISTRAR'S SIGNATURE FEB 17 1967

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02426

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02419

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB 7 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2214 COLSTON DRIVE #203				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2214 COLSTON DR. #203 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MAURICE RAMON O'CONNOR				4. DATE OF DEATH Month Day Year FEBRUARY 25 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1896	
9. AGE (in years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S. COURT DIST. OF COL.		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS O'CONNOR				14. MOTHER'S MAIDEN NAME CATHERINE FENTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-03-1506		17. INFORMANT MARGARET E. O'CONNOR (WIFE)		Address 2214 COLSTON DR #203 SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 0
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/25/1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-28-67		23c. NAME OF CEMETERY OR CREMATORY State of Heaven Cem.		23d. LOCATION (City, town or county) (State) SILVER SPRING MD.	
24. FUNERAL DIRECTOR W.W. CHAMBERS INC				25a. REC'D BY REGISTRAR MAR 1 1967			
ADDRESS SILVER SPRING, MD.				25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02427

CERTIFICATE OF DEATH

02420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c LENGTH OF STAY IN 1b <u>MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>		d STREET ADDRESS <u>2924 TERRACE DRIVE</u>	
3 NAME OF DECEASED (Type or print) <u>ANNE</u> <u>OSTROLEW</u>		4 DATE OF DEATH <u>FEB</u> <u>15</u> 19 <u>67</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JULY 15-1898</u> <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY BERICK</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17 INFORMANT <u>DEENA</u>		Address <u>CHEVY CHASE</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cedonocarcinoma, Breast, multiple metast.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>170X</u> (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>2/15/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/15/67</u> , 19 <u>67</u> , and that death occurred at <u>3:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs M.D.</u>		22b. DATE SIGNED <u>2/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs M.D.</u>		22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>ROCHELLE PK. N.J.</u>
24. FUNERAL DIRECTOR <u>Wedding Funeral Home 4217 9th St. NW</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>P. Chas. J. [Signature]</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02428

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02421

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>Riverdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>6106-44th Pl.</u>	
3 NAME OF DECEASED (Type or print) <u>Mamie</u> First <u>Pannebaker</u> Middle <u>Pannebaker</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-23-86</u>
9 AGE (n years last birthday) <u>80</u> yrs		10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Government Printing Office</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Jacobs</u>		14 MOTHER'S MAIDEN NAME <u>Emma Pouche</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>217 3668 55</u>	
17 INFORMANT <u>Hosp. record</u>		Address <u>Takoma Park Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure accompanied by</u> <u>921.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Asphyxia due to aspiration of gastric contents</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. or Part II. of item 18) <u>Deceased vomited and aspirated gastric contents</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:00</u> am <u>pm</u> <u>2-17</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>hospital</u>	20f. (City or town) (County) (State) <u>Takoma Park Montg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>2/17/1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>W. H. Hester</u> Address (Street, City, Town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	23d. LOCAT ON (City or Town) (County) (State) <u>Beltsville Pro Geo Md.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>FEB 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	



- Cleared to medical Examiner after 11/23/2000

65

CERTIFICATE OF DEATH

22429

02422

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived, If (institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN ID <u>3 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		d. STREET ADDRESS <u>9219 Adelaide Dr.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jeffrey L. PARKS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/66</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months <u>17</u> Days <u>25</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William L. PARKS</u>		14. MOTHER'S MAIDEN NAME <u>Barbara N. Nichols</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>William Parks</u>		Address <u>9219 Adelaide Drive, Bethesda</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion + edema severe</u> DUE TO (b) <u>overwhelming infection (viral)</u> DUE TO (c) <u>+ poss. encephalitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty Change 2 liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>67</u> , to <u>2/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/23/67</u> , and that death occurred at <u>4</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Murray Paul</u>		22b. DATE SIGNED <u>2/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Murray Paul</u>		22d. ADDRESS <u>1040 University Blvd. E., S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 2 1967</u>	

Murray Paul

1040 University Blvd. E., 2-2, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

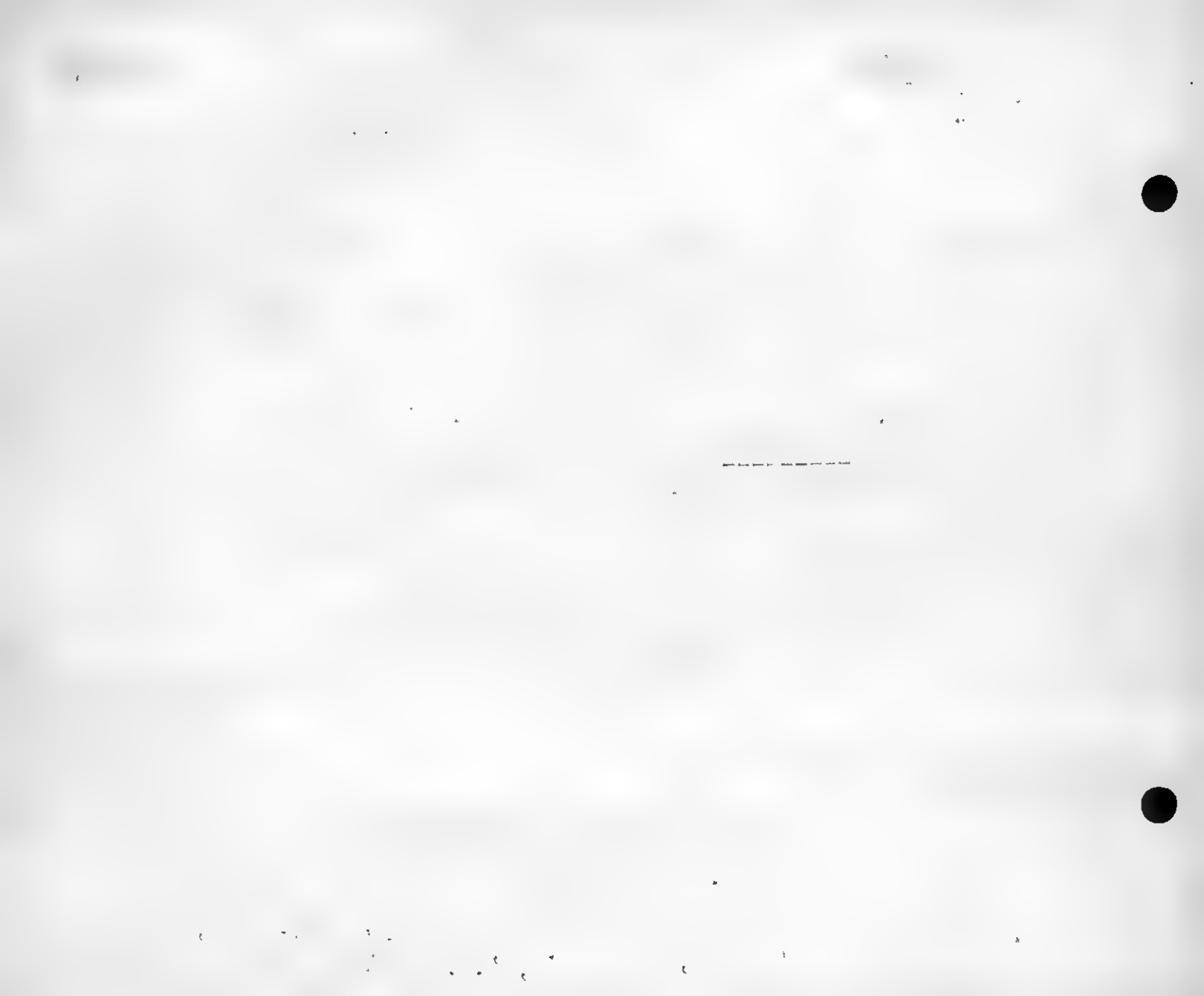
FOR STATE
HEALTH DEPT.

02430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02423

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 2Hr. 4Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				d. STREET ADDRESS 3001 SHEPHERD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James C. PASCAL				4. DATE OF DEATH Month Feb Day 24 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1905	9. AGE (In years to birthday) 71 yrs	10. UNDER 1 YEAR Months 1 Days 7 Hours 1 Min 1		11. UNDER 24 HRS Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN E. TOOLEY				14. MOTHER'S MAIDEN NAME M. SHOLE O'NEILLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT JOHN KENNETH DAUGHTER Address CHEVY CHASE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - massive - DUE TO Carotid Vascular Disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carotid Vascular Disease - DUE TO years (c) years						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball M.D. EXAMINER'S NAME (Type) John G. Ball				22. DATE SIGNED 2/24/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/25/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.				25. REC'D BY REGISTRAR Charles Judge			



02431

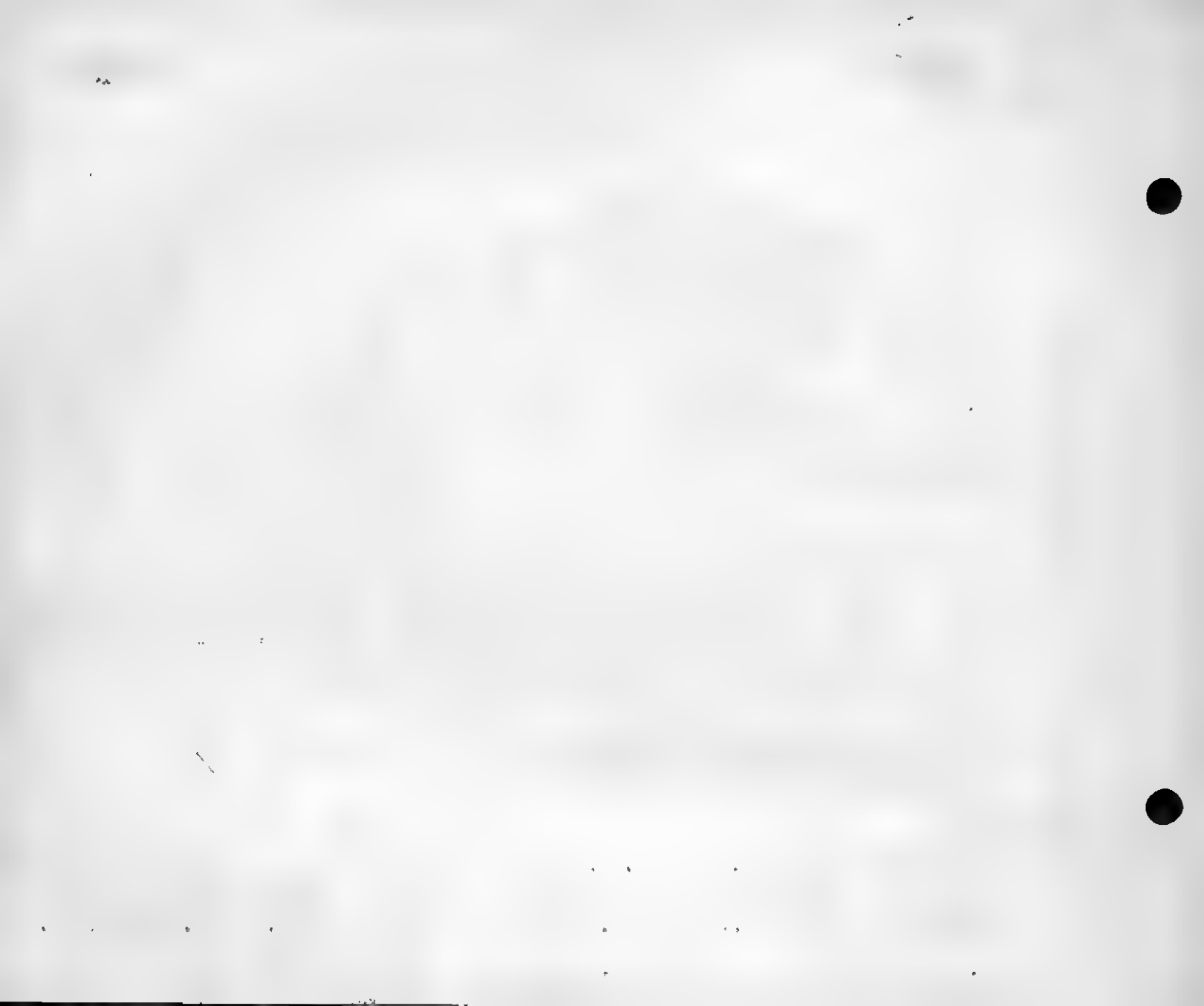
CERTIFICATE OF DEATH

02424

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>				d. STREET ADDRESS <u>712 Hankin Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard Simms Peacock</u>				4. DATE OF DEATH Month Day Year <u>February 27 1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28 89</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver Capital</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Joseph Peacock</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cunningham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>578-10-5236</u>		17. INFORMANT <u>Patients Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Progressive Thrombosis</u> DUE TO <u>Bilateral Mitral & Aortic Valve Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Adenocarcinoma of Lung</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-25</u> , 19 <u>67</u> , to <u>2-27</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>2-27</u> , 19 <u>67</u> , and that death occurred at <u>3:51</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Douglas K. Potts M.D.</u>				22b. DATE SIGNED <u>2-28-67</u>		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <u>Douglas K. Potts M.D.</u>				22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>		23d. LOCATION (City or Town) (County) (State) <u>Ridge, St. Mary's, Md.</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02432

CERTIFICATE OF DEATH

02425

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 136 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 6246 33rd Street, N.W.	
3 NAME OF DECEASED (Type or print) First Middle Last Gary Carl Peterson		4 DATE OF DEATH Month Day Year February 15 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 26, 1956
9 AGE (In years last birthday) 10 yrs		10 IF UNDER 1 YEAR Months Days Hours Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Arthur G.C. Peterson		14. MOTHER'S MAIDEN NAME Ruth Ainley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medulloblastoma, metastatic, glioblastoma/ 1737 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ QUE TO (c) _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 2, 1966 , to Feb. 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 15 19 67 , and that death occurred at 3:45 M. from causes on and on the date stated above.			
22a. SIGNATURE Duane B. Gainsburg		22b. DATE SIGNED 15 February 1967	
22c. PHYSICIAN'S NAME (Type) Duane B. Gainsburg, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/17/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24 FUNERAL DIRECTOR WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR FEB 20 1967	25b. REGISTRAR'S SIGNATURE James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

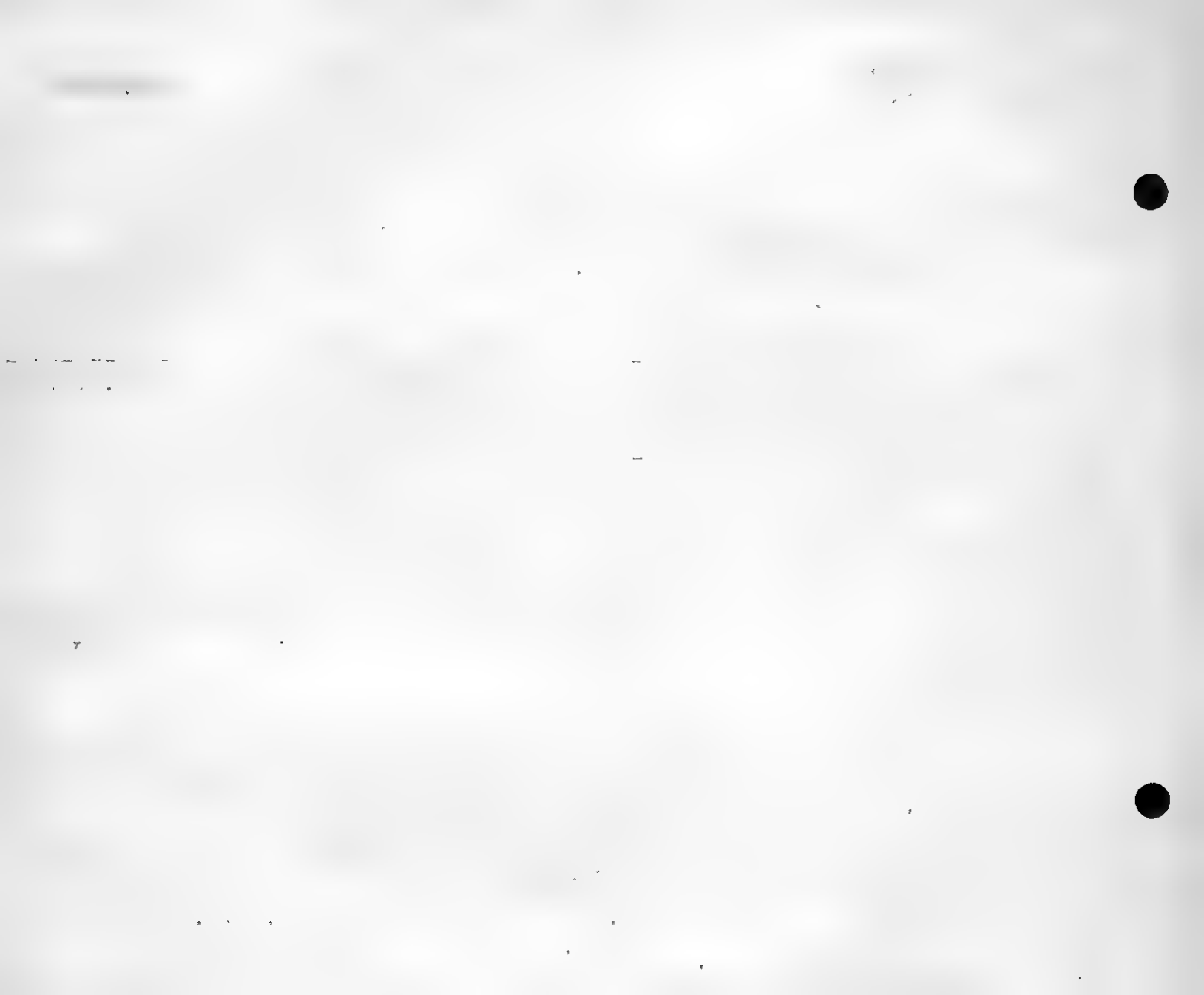
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02433		02426	
1 PLACE OF DEATH a COUNTY <u>Mont</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admisson) a STATE <u>md</u> b COUNTY <u>mont</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN lb <u>15-1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1121 Cresthaven Dr</u>		d STREET ADDRESS <u>1121 Cresthaven Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Luba I. Petrusk</u>		4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-13-1890</u>
9 AGE (In years last birthday) <u>77</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11 BIRTHPLACE (State or foreign country) <u>Ukraine</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Eugene Huzar</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Riedl</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>119-28-1881</u>	
17 INFORMANT <u>Mykola Stawnychy-Son</u>		Address <u>Same as L.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Massive Subarachnoid</u> DUE TO (b) <u>Hemorrhage</u> DUE TO (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) <u>-</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f (City or town) (County) (State) <u>-</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>2/25/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street and town or county) <u>-</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2/28/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Wash., D.C.</u>
24 FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a REC'D BY REGISTRAR <u>Mar 1 1967</u>	
ADDRESS <u>Mt. Rainier, Maryland</u>		25b REC'D BY REGISTRAR <u>John Judge</u>	



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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02434

CERTIFICATE OF DEATH

02427

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u>		d. STREET ADDRESS <u>17 WALKER AVENUE</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>D</u> Last <u>PHOEBUS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/1887</u>
9. AGE (In years lost birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>RR Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montg Co - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Phoebus</u>		14. MOTHER'S MAIDEN NAME <u>Agnes English</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Thomas W. Phoebus</u>		Address <u>403 Dogwood Gaithersburg, Md Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia - 2nd attack 10/19/66</u> DUE TO (b) <u>Cerebral accident 1st April 1960</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct - 19 - 1966</u> to <u>Feb - 25 - 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb - 22 - 1967</u> , and that death occurred at <u>10 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William C. Miller</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		22d. ADDRESS <u>7 Brooks Ave., Gaithersburg, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Giffner</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>	
ADDRESS <u>Gaithersburg</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02435

CERTIFICATE OF DEATH

02428

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Forestville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY in 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 7305 Keystone Lane, Apt. 102		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amy Middle Beth Last PIEPGRAS				4. DATE OF DEATH Month February Day 14 Year 1967			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1966	
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 163		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Md.	
13. FATHER'S NAME David G. Piepgras				14. MOTHER'S MAIDEN NAME Jane Ann Nilan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wpr or dates of service) N/A				16. SOCIAL SECURITY NO. N/A		17. INFORMANT Lane, Apt. 102 Address Forestville, Md Capt. David G. Piepgras, USAF, 7305 Keystone	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aortic stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congenital malformation of the heart DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 13 , 19 67 , to Feb. 14 , 19 67 that (I) (we) lost saw the deceased alive on February 14 19 67 , and that death occurred at 425A M, from causes and on the date stated above.							
22a. SIGNATURE Jerry J. Tomasovic M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED Feb. 15, 1967			
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION (City or Town) (County) (State) Luverne, Minnesota	
24. FUNERAL DIRECTOR Robert E. Wilhelm ADDRESS D. C.				25a. REC'D BY REGISTRAR DATE FEB 20 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
Funeral Home, 4308 Suitland Rd., S.E. Wash.							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02429

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. STREET ADDRESS <u>4998 Battery Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katie</u> First <u>M</u> Middle <u>Pingree</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/94</u> 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland - Hartford Co</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wm. H. Poplar</u>		14. MOTHER'S MAIDEN NAME <u>Annie C. Murrin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-6692B</u>	17. INFORMANT <u>Katie - Nellie Brutt</u> Address <u>4890 Battery Lane Bethesda, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute Coronary Thrombosis</u> DUE TO (b) <u>Coronary Arteriosclerosis Severe</u> DUE TO (c) <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adeno-Carcinoma of Rectum with bleeding</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>2/13/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

02437

CERTIFICATE OF DEATH

02430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit. at on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>4998 Battery Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Logan Pingree</u>		4. DATE OF DEATH <u>Feb. 22 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-86</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>22</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Excavating Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Logan Pingree Co.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Pingree</u>		14. MOTHER'S MAIDEN NAME <u>Nettie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-6692</u>	
17. INFORMANT <u>MRS. Pierce Britt</u>		Address <u>401.306 4890 Battery Lane Bldg.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction, multiple acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>502A</u> (b) <u>Cerebral arteriosclerosis</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced coronary arteriosclerosis & mesenteric thrombosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1755</u> , 19 <u>67</u> , to <u>Feb 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 21</u> , 19 <u>67</u> , and that death occurred at <u>3A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Robert H. Coale</u>		22b. DATE SIGNED <u>Feb 22, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane Chevy Chase Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>



02438

CERTIFICATE OF DEATH

02431

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified & will Approve.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Conn. b. COUNTY Fairfield v	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Fairfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring, Nursing Home		d. STREET ADDRESS 723 S. Pine Creek Rd.	
3. NAME OF DECEASED (Type or print) First LOUISE Middle B. Last POLK		4. DATE OF DEATH Month Feb. Day 14, Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1879
9. AGE (n years last birthday) yrs 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Burr		14. MOTHER'S MAIDEN NAME Catherine Sherwood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 132-18-9219J1	
17. INFORMANT Daughter 4914 Dorset Ave. Bethesda, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, GASTRIC DUE TO (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c) ARTERIO-SCLEROSIS, CEREBRAL	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 10 YEARS 3 MOS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 13, 1967 , to FEB 14, 1967 , that (I) (we) last saw the deceased alive on FEB 13, 1967 , and that death occurred at 5:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Philip R. James		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) PHILIP R. JAMES		22d. ADDRESS Washington Clinic Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-15-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02439

CERTIFICATE OF DEATH

02432

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Talbot Hill</u>		c. LENGTH OF STAY IN IB <u>45 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>			d. STREET ADDRESS <u>10416 Rodney Rd.</u>		
3. NAME OF DECEASED (Type or print) <u>IMOGEN</u> First Middle <u>Close</u> Last <u>Pool</u>			4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-87</u>		9. AGE (in years last birthday) <u>79</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court reporter</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>James T. Close</u>			14. MOTHER'S MAIDEN NAME <u>McRAINE SEATON</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>261-58-9361</u>	17. INFORMANT <u>Mrs. Basil Rittenhouse</u> Address <u>10416 Rodney Rd. Silver Spring, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular failure</u> DUE TO <u>malnutrition + anemia</u> (b) <u>metastatic</u> DUE TO <u>metastatic</u> (c) <u>metastatic of the left lung</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>chronic pleural effusion of left leg.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Te.</u>		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>2-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>67</u> , and that death occurred at <u>4:00 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Veronica Troost</u> M.D.			22b. DATE SIGNED <u>2-5-1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST MD</u>			22d. ADDRESS <u>10236 N. H. Ave. S.S. Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandy Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>			25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>W. Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02440

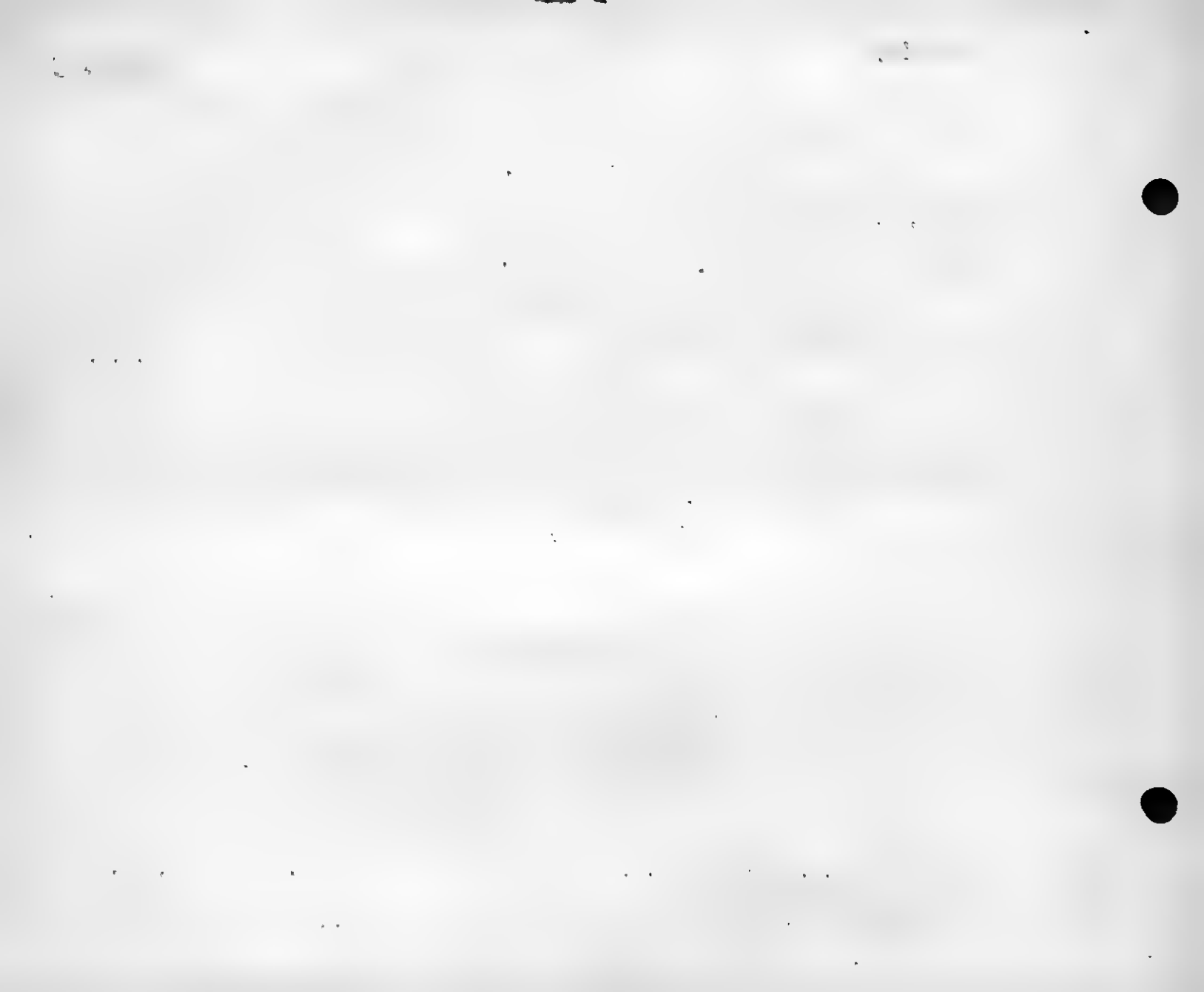
CERTIFICATE OF DEATH

02433

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 6 yrs, 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol, give street address) Resmor, 5721 Grosvenor Lane		d. STREET ADDRESS 7501 Persimmon Tree Road	
3. NAME OF DECEASED (Type or print) Texie B. Pool		4. DATE OF DEATH Month February Day 10 Year 1967	
SEX f	5. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State or foreign country) North Carolina	
13. FATHER'S NAME Burrell Bowman		14. MOTHER'S MAIDEN NAME Katherine Sherrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter Katherine Stone		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Cerebral vascular thrombosis DUE TO (c) Cerebral and cardiac arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH several weeks many yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/23 , 19 67 , to 2/10 , 19 67 , that (I) (we) last saw the deceased alive on 2/8 , 19 67 , and that death occurred at 1:10a M, from causes and on the date stated above.			
22a. SIGNATURE G.H. Mitchell		22b. DATE SIGNED 2/10/67	
22c. PHYSICIAN'S NAME (Type) G.H. Mitchell, M.D.		22d. ADDRESS 4890 Battery Ln., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-13-67	23c. NAME OF CEMETERY OR CREMATORY THREE FORK BAPTIST CEM., TAYLORSVILLE, NORTH CAR	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR BETHESDA, MARYLAND	
25b. REGISTRAR'S SIGNATURE ROLINA		DATE FEB 17 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02441

02434

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 Hr 10 Min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>10416 Montrose Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Price</u> Last <u>Poor</u>				4 DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 19-1896</u>	9 AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u>		IF UNDER 24 HRS Hours <u>10</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State, or foreign country) <u>St. Louis, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Price</u>				14. MOTHER'S MAIDEN NAME <u>Emma Beaty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-50-9253</u>		17. INFORMANT <u>Husband. Russell Poor</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio-Vascular Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>2/8/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REG. STRAITS SIGNATURE	
				DATE <u>FEB 17 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02442

CERTIFICATE OF DEATH

02435

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 300 Frederick Ave.		d. STREET ADDRESS 300 Frederick Ave.	
3. NAME OF DECEASED (Type or print) First HENRY Middle PRATHER Last		4. DATE OF DEATH Month Feb. Day 14, Year 1967	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1893
9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months 1 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Prather		14. MOTHER'S MAIDEN NAME Evelyn Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Josephine Prather		Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Feb 1967 , that (I) (we) last saw the deceased alive on 20 Jan 1967 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS [Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/17/67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Park	23d. LOCATION (City, town or county) (State) Rockville, Maryland
24. FUNERAL DIRECTOR [Signature]		25a. REC'D BY REGISTRAR [Signature]	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE FEB 21 1967	

02443

CERTIFICATE OF DEATH

02436

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c LENGTH OF STAY IN lb 7 Months	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d STREET ADDRESS 7606 Whittier Blvd.	
3 NAME OF DECEASED (Type or print) RICHARD R. PRICE		4 DATE OF DEATH Month Feb. Day 16, Year 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 29, 1878
9 AGE (In years and birthday) 88 yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D. C. Policeman		10b KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Price		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. A 577-30-3106	
17. INFORMANT Son		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Multiple cerebral thromboses DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH several hours several months many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia and chronic bronchitis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS <input checked="" type="checkbox"/> NOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f ((City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 to Feb 16 , 1967, that (I) (very) last saw the deceased alive on Feb 8 , 1967, and that death occurred at 2 A.M. from causes and on the date stated above.			
22a SIGNATURE George H. Mitchell		22b DATE SIGNED Feb 16, 1967	
22c PHYSICIAN'S NAME (Type) GEORGE H. MITCHELL		22d ADDRESS 11125 Rockville Pike Rockville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 2-18-67	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR REC 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE
HEALTH DEPT.

02445

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02438

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If only day is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY in 1b <u>30 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM and HOSPITAL</u>		e. STREET ADDRESS <u>13121 Clifton Rd. S.S.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>THOMAS</u> Last <u>PRISK</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-75</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE OFFICIAL IN STATE OF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LITAN</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>MARTIN PRISK</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE HARRIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-52-6025</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute, severe</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningioma, rt. Cerebellar hemisphere</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>Feb. 4, 1967</u>		DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Hirtach Walters</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02446

CERTIFICATE OF DEATH

02439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE c. LENGTH OF STAY IN 1b 10401 GROSVENOR PLACE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10401 GROSVENOR PLACE		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 10401 GROSVENOR PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AUGUSTA First Middle Last RAPPAPORT		4. DATE OF DEATH FEBRUARY 16 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 20, 1916
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAN MULLER		14. MOTHER'S MAIDEN NAME ROSE LEBISH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HUSBAND		18. ADDRESS 10401 GROSVENOR PL. ROCKVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pleural effusions DUE TO (b) Metastatic carcinoma of DUE TO (c) right breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVA. BETWEEN ONSET AND DEATH 1 year 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE 1965 to 2-16 1967 that (I) (we) lost saw the deceased alive on 2-15 1967 , and that death occurred at 4:45 M, from causes and on the date stated above.			
22a. SIGNATURE JASON GEIGER, M.D.		22b. DATE SIGNED 2-16 67	
22c. PHYSICIAN'S NAME (Type) JASON GEIGER, M.D.		22d. ADDRESS 800 PERRYMAN DRIVE SILVER SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-19-67	23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	23d. LOCATION (City or Town) (County) (State) FALLS CHURCH, VA.
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS		25a. REC'D BY REGISTRAR WASHINGTON, DC	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 20 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02447

CERTIFICATE OF DEATH

02440

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN IB D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 3225 Verona Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred A. Reap				4. DATE OF DEATH Month Day Year 2 26 1967	
5. SEX female	6. COLOR OR RACE cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/02		9. AGE (In years last birthday) 65 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME John E. Armstrong			14. MOTHER'S MAIDEN NAME Blanche C. Greene		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Belden Reap Address 3225 Verona Drive Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY ARTERY SCLEROSIS DUE TO 5 YEARS					INTERVAL BETWEEN ONSET AND DEATH 1 DAY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA					19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/23	
20f. (City or town) 1965		20g. (County) 2/16		20h. (State) 67	
21. I certify that (I) (this hospital) attended the deceased from 6/23 , 19 65 , to 2/16 , 19 67 that (I) (we) last saw the deceased alive on 11/22 , 19 66 , and that death occurred at 12 P M, from causes and on the date stated above.					
22a. SIGNATURE David Goldenberg		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/26/67	
22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG		22d. ADDRESS 10620 GEORGIA SILVER SPRING MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF March 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Maple Flats Cemetery	
23d. LOCATION (City or Town) Cleveland, New York		23e. (County) Cleveland		23f. (State) New York	
24. FUNERAL DIRECTOR John S. Thomas		ADDRESS 434 Georgia Ave.		25a. REC'D BY REGISTRAR Charles Judge	
24b. REGISTRAR'S SIGNATURE Barner E. Pumphrey		24c. ADDRESS Inc. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Closed with Dr. John Ball, Deputy Medical Examiner 2/26/67

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02448

02441

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY in 1b <u>DOA</u>		d. STREET ADDRESS <u>14700 Crossway Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>George Earl Reed</u>		4 DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>69</u> yrs
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Sales</u>		9b UNDER 1 YEAR Months <u>0</u> Days <u>0</u> HOURS <u>0</u> MIN <u>0</u>	
10a KIND OF BUSINESS OR INDUSTRY <u>Trucks & Truck Bodies Pa.</u>		11 BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13 FATHER'S NAME <u>Unknown</u>	
14 MOTHER'S MAIDEN NAME <u>Unknown</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16 SOCIAL SECURITY NO <u>578-16-7353</u>		17. INFORMANT <u>Elizabeth Reed - wife</u> Address <u>14700 Crossway Rd Rockville Maryland</u>	
B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>456X Dissection of ascending aorta with</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>hemopericardium and cardiac tamponade</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): _____			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Feb 24, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d LOCATION (City or town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>Glenn Carter</u> ADDRESS <u>8424 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>Charles J. Jager</u> 25b REGISTRAR'S SIGNATURE <u>2/21/1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



02449

CERTIFICATE OF DEATH

02442

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b W. Hyattsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San & Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville d. STREET ADDRESS 1436 Kanawha Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ABRAHAM RESNIK		4. DATE OF DEATH Month February Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1891
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Food	
11. BIRTHPLACE (County & State, or foreign country) Rudssia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hyman Resnik		14. MOTHER'S MAIDEN NAME Zelda	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Israel Resnick, 10119 Brock Dr., SSpg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aneurysmal Rupture at site of 21 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction - 54 DUE TO myocardial infarction - '61 (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 10 , 19 65 , to Jan 10 , 19 67 , that (I) (we) last saw the deceased alive on Jan 10 , 19 67 , and that death occurred at SP from causes and on the date stated above.			
22a. SIGNATURE Aaron Nimetz		22b. DATE SIGNED Feb 6-67	
22c. PHYSICIAN'S NAME (Type) Aaron Nimetz		22d. ADDRESS 5501 16th Street N.W., Wash., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-67	
23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem., Inc.		23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR Goldberg Funeral Home - 4217 9th St. N.W., D.C.		25a. REC'D BY REGISTRAR DATE FEB 8 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02450

CERTIFICATE OF DEATH

02443

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY P.G. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH SANT HOSPITAL		e. STREET ADDRESS 4004 38TH ST	
3 NAME OF DECEASED (Type or print) CHARLES STUART RHODES		4 DATE OF DEATH Month 2 Day 20 Year 19 67	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-04
9. AGE (in years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRINTER		10b. KIND OF BUSINESS OR INDUSTRY D.C.	
11 BIRTHPLACE (County & State, or foreign country) D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME DAVID RHODES		14 MOTHER'S MAIDEN NAME ANNABELLE WALPORT	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO CHART	
17. INFORMANT CHART		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen Arteriosclerosis & Heart block DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thrombosis Abcl. Aorta			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 17, 1967 , to Feb 20, 1967 , that (I) (we) last saw the deceased alive on Feb 19, 1967 , and that death occurred at 2:44 M , from causes and on the date stated above.			
22a. SIGNATURE Lloyd H. Scribner		22b. DATE SIGNED 2-20-67	
22c. PHYSICIAN'S NAME (Type) LLOYD H. SCRIBNER		22d. ADDRESS 831 UNIV. BLVD E SPRING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/23/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REG STRAR DATE FEB 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove person papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

02451

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02444

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c LENGTH OF STAY IN 1b Rockville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 14102 Parkland Drive e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY FRANKLIN ROBERTS		4. DATE OF DEATH Month FEB. Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bio Chemist		10b. KIND OF BUSINESS OR INDUSTRY NIH	11. BIRTHPLACE (State or foreign country) Meigs, Georgia
13. FATHER'S NAME James Roberts		14. MOTHER'S MAIDEN NAME Nancy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. #2		16. SOCIAL SECURITY NO W.W. #2	
17. INFORMANT Mrs. Marie Roberts - 14102 Parkland Dr.		Address Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute asphyxiation due to aspiration of 721.0 DUE TO gastric contents accompanied by (b) acute myocardial insufficiency and DUE TO acute hemorrhagic pancreatitis (c) acute hemorrhagic pancreatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased vomited & aspirated gastric contents	
20c. TIME OF INJURY Month Day, Year 8:50 hour a.m. 2/14 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ice bldg., etc.) Home
20f. (City or town) Rockville		(County) Montg.	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BIRTHAL, CREMATION, BURIAL, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/17/67	
23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION (City or town) Moultrie, Georgia	
24. FUNERAL DIRECTOR Lyson Wheeler Funeral Home		ADDRESS 1551 Rock. Pike	
25a. REC'D BY REGISTRAR DATE FEB 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File immediately with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and event within 72 hours after death.

FOR STATE
HEALTH DEPT.

02452

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02445

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN ID	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8209 Roanoke Ave</u>		d. STREET ADDRESS <u>8209 Roanoke Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Allan</u> Middle <u>D.</u> Last <u>Rogers</u>		4 DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-28-44</u>
9 AGE (In years lost birthday) <u>22</u> yrs		IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Takoma Park, Md.</u>	
11 BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Calvin Rodgers</u>		14 MOTHER'S MAIDEN NAME <u>May Steward</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOC. SEC. NO. <u>10-28-44</u>	
17 INFORMANT <u>May Steward</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral laceration and</u> DUE TO (b) <u>Hemorrhage due to gunshot wound in head</u> DUE TO (c) <u>lost</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c);		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18) <u>Deceased shot self in right temple</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:05 pm 2-25 1967</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or <input type="checkbox"/> not at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Takoma Park Mont. Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>March 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or town) (County) (State) <u>Adelphi Md.</u>	
24 FUNERAL DIRECTOR <u>J. Arthur Walters, 204 Canal St. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 2 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02453						02446					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					
c. LENGTH OF STAY IN ID <u>3 Mos.</u>						d. STREET ADDRESS <u>8107 Garland Ave.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The MARYLANDER HOME of RES., Inc.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ISRAEL</u> First <u>CYRIL</u> Middle <u>ROTHMAN</u> Last						4. DATE OF DEATH <u>FEB.</u> Month <u>4</u> Day <u>1967</u> Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-1880</u>		9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Dye Maker, retd.</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alter Rothman</u>						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>383-1019-68A</u>		17. INFORMANT Address <u>8107 Garland Ave. Tak. Pk. Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interosclerotic cardiovascular disease</u> <u>4221</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>10 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>66</u> , to <u>2/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>James P. Kerr</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/4/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES P. KERR</u>						22d. ADDRESS <u>Ridge Road, Damascus, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Mdm. Gar.</u>		23d. LOCATION (City, town or county) (State) <u>Falls Ch., Va.</u>					
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons NW, Wash. DC.</u>						ADDRESS <u>3501-14th St</u>		24a. REC'D BY REGISTRAR <u>FEB 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04130

04130



CERTIFICATE OF DEATH

02454

02447

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, give name before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalltown</u> d. STREET ADDRESS <u>8607 Liberty Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Madeline</u> <u>Suzanna</u> <u>Ruby</u>		4. DATE OF DEATH Month Day Year <u>February</u> <u>6</u> <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>6</u> <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John T. Pumphrey</u>	
14. MOTHER'S MAIDEN NAME <u>House Stinchcomb</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records - Washington Sanitarium & Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>9-10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, Urinary tract infection</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1967</u> to <u>Feb 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 6, 1967</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Boris RARKIN</u>		22b. DATE SIGNED <u>2/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Boris RARKIN</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10 Feb. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md. 21225</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

02143

02143

1907 . . . 1908

1909 . . . 1910

1911 . . . 1912